MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09159

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4609 Quales Street, N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: Sp.Am.

3.(a) FULL NAME: AMMANN, Charles

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Grace S. Ammann

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 24, 1872

8. AGE: Years	Months	Days	If less than one day
75	2	27	hrs. min.

9. Birthplace: Switzerland
(Town, county, and state)

10. Usual occupation: unemployed

11. Industry or business:

FATHER — 12. Name: AMMANN, Charles dec

13. Birthplace: unknown

MOTHER — 14. Maiden name: Bertha ? dec

15. Birthplace: Switzerland

16. Informant: wife: Mrs. Grace S. Ammann

Address: 4609 Quales St., N.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 10-24-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Virginia

18. Funeral director: S. H. HINES Rtd.

Address: 2901 14th St., N.W., Wash., D.C.

19. 10-21 19 47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 October 19 47 at 10:31A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 October 19 47 to 21 Oct. 19 47 and that I last saw h im alive on 21 October 19 47

Immediate cause of death	DURATION
Congestive Heart Disease	6 mo+
Due to: Hypertension	+-5 yrs.
Due to: Secondary Anemia	indef.
Other conditions: Arteriosclerosis	2-3 yrs.
* Carcinoma of Stomach	indef.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: continued above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. L. C. Stevens H. L. C. STEVENS, Cdr. USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 10-21-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55d K

CERTIFICATE OF DEATH

Reg. Diat. No. 09160 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3½ hours

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3½ hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3634 Upton St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ANDERSON, Muriel Buttling

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife: George Whelan Anderson, Jr.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November 9, 1911

8. AGE: Years	Months	Days	If less than one day
35	10	11	..... hrs. ..... min.

9. Birthplace: N.Y.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER — 12. Name: Buttling, Albert J. dec.

13. Birthplace: N.Y.

MOTHER — 14. Maiden name: Bacon, Annette dec.

15. Birthplace: N.Y.

16. Informant: husband: Capt. George W. Anderson, Jr.

Address: 3634 Upton St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 22, 1947 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS A.P.

Address: 1400 Chapin St., N.W., Wash., D.C.

19. 10-20 47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 20 October 19 47, at 7:40A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 October 1947 to 20 Oct. 1947 and that I last saw her alive on 20 October 1947

Immediate cause of death	DURATION
Asphyxiation	5 min
Due to: Massive Hemorrhage	10 min
Due to: Erosion of Carotid Artery by Carcinoma of left maxillary sinus	2 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of left maxillary sinus Date of op.

Autopsy results: Carcinoma left maxillary sinus

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: William F. Stengel M.D. M. D. or other

Address: U.S. National Naval Medical Center, Bethesda Date signed: 10-20-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The color of age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09161

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 41 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1812 24th Place, S.E.

(If rural, give LOCATION)

2.(a) If veteran, name war: WW I ✓

3.(a) FULL NAME: ARCHER, Frank Phillip

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Lonie Archer

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): February 23, 1894

8. AGE:

Years	Months	Days	If less than one day
53	7	15	....hrs. ....min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: D. C. Fire Department

FATHER

12. Name: ARCHER, Irvin dec

13. Birthplace: Ga.

MOTHER

14. Maiden name: PALMEROY, Lucy dec

15. Birthplace: N.Y.

16. Informant: wife: Mrs. Lonie Archer

Address: 1812 24th Place, S.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 10-11-47 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln

Location: Hyattsville, Md.

18. Funeral director: Lee Funeral Home Smith D.

Address: 4th & Mass., Avenue, N. E., Wash., D.C.

19. Oct. 9 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8 19 47 at 7:35P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 28 1947 to Oct. 8 1947 and that I last saw him alive on 8 October 1947

Immediate cause of death	Pulmonary Embolism.	DURATION 8 hours
Due to (1)		
Due to (2)	Tuberculosis, Pulmonary (Inactive)	7 yrs
Other conditions	Squamous Carcinoma of Tongue & Throat	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operation: No surgery. Date of op.

Autopsy results: none.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. A. Murphy. J. A. MURPHY, Cdr. MC USN M. D. or other

Address: USNH Bethesda, Md. Date signed 10-9-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

09162

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One Month
Hospital, institution, or street address where death occurred:
4860 Chevy Chase Blvd.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town 4860 Ch. Ch. Blvd., Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4860 Chevy Chase Blvd.
(If rural, give LOCATION)
2.(a) If veteran, name war No.

3. (a) FULL NAME
SAMUEL RUSSELL BAKER

3. (b) Social Security Number
223-26-5842

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Fannie A. Baker
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feburary 25, 1875

8. AGE: Years	Months	Days	If less than one day
72	7	7	— hrs. — min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Office Mgr.
11. Industry or business Cleaning Establishment

FATHER
12. Name Samuel F. Baker
13. Birthplace Virginia

MOTHER
14. Maiden name Julia Holmes
15. Birthplace Virginia

16. Informant Mrs Fannie A. Baker
Address 4860 Ch.Ch.Blvd. Ch. Ch. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 4 1947 (month) (day) (year)
Cemetery or crematory Forest Oak Cemetery
Location Gaithersburg, Md.
18. Funeral director Wm. Reuben Pumphrey
Address Bethesda, Maryland

19. 10/3/47 (Date rec'd by registrar) Wm E Johns Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 1947 at 6:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1 1947 to Oct 2 1947 and that I last saw h... alive on Oct 2 1947

	DURATION
Immediate cause of death Heart Failure	9 hours
Due to Valvular Heart Disease	Many years
Due to	
Other conditions Asthma	7 years

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. —
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Bradley D Hodgkins M.D.
M. D. or other
Address 313 W Bradley Lane Date signed 10/2/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The occupation is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216 — 09163

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County:

City or town: Springfield
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route #1, Box 18
(If rural, give LOCATION)

2.(a) If veteran, name war: WW II

3.(a) FULL NAME: BARKER, Roger Linden

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 12-22-1900

8. AGE: Years	Months	Days	If less than one day
46	9	18	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business: Civil Service

FATHER
12. Name: Roger Franklin Barker
13. Birthplace: Virginia, deceased

MOTHER
14. Maiden name: Mary M. Moore
15. Birthplace: Virginia, deceased

16. Informant: Sister: Mrs. Virginia Waddell
Address: Rt #1, Box 18, Springfield, Virginia

17. burial (Burial, cremation, or removal. Which?) Date thereof: 10-14-47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: W. W. Chambers Co. a. P.

Address: 517 11th St., SE, Washington, D. C.

19. 10-11 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 October 19 47 at 1:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-25- 19 47 to 10-10-47 19 and that I last saw him alive on 10-10-47 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	duckf
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: Tuberculosis Tuberculosis - all lobes

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. L. FLECK, Lieut MC USN
M. D. or other

Address: USNH, Bethesda, Md. Date signed: 10-11-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

CERTIFICATE OF DEATH

Reg. Dist. No. 09164

1. PLACE OF DEATH:

County MONTGOMERY

City or town ROCKVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 YEARS

Hospital, Institution, or street address where death occurred:
FALLS ROAD

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY

City or town ROCKVILLE
(If outside city or town limits, write RURAL and give nearest town)

Street No. FALLS ROAD.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME LAURA FLORENCE BENNETT

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife WILLIAM L. BENNETT

6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) JUNE 14 1884

8. AGE: Years 63 | Months 5 | Days 2 | If less than one day ..... hrs. ..... min.

9. Birthplace BROADWAY VIRGINIA.
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business HOME

FATHER
12. Name MICHAEL SCOTHORN
13. Birthplace VA.

MOTHER
14. Maiden name MARY A DAUGHTERY
15. Birthplace VA.

16. Informant HAZEL B. HUGHES
Address FALLS RD ROCKVILLE MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 20th 1947 (month) (day) (year)

Cemetery ~~or crematory~~ Flower Hill Cemetary

Location Redland Md

18. Funeral director W. W. Chambers

Address 1400 Chapin St. N.W. Wash. D.C.

19. Oct. 17th 1947 (Date rec'd by registrar) E P Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 6 1946, to 16 Oct 1947 and that I last saw h[illegible] alive on 16 Oct 1947

	DURATION
Immediate cause of death Cerebral Hemorrhage	6 hrs.
Due to Hypertension	10 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. W. Chambers M.D. M. D. or other

Address Rockville Md Date signed Oct 19 1947

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Authorization to change cause of death see letter; Dr. Eisberg, Nov. 7, 1947 ams.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

556 K

CERTIFICATE OF DEATH

09165

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months, 7 days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 9 months, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County P. G. co.

City or town Mount Ranier
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4207 Russell Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war WW I

3. (a) FULL NAME BLACKMAN, Walter Morrell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Gena A. Blackman

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) 19 December 1897

8. AGE: Years	Months	Days	If less than one day
49	10	11	... hrs. ... min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual occupation Civil Service

11. Industry or business Post Office Department

FATHER
12. Name John Blackman
13. Birthplace South Carolina, deceased

MOTHER
14. Maiden name Mary Webb
15. Birthplace South Carolina, deceased

16. Informant Wife: Mrs. Gena A. Blackman

Address 4207 Russel Ave., Mt. Ranier, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 11 (month) 3 (day) 47 (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington, Virginia

18. Funeral director S. H. Hines Funeral Home (S. P.)

Address 2901 14th St., NW, Washington, D. C.

19. 10-31 19 47 (Date rec'd by registrar) Mary C. Patterson Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 October 19 47 at 10:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-23- 19 47, to 10-30- 19 47 and that I last saw him alive on 10-30- 19 47

Immediate cause of death ~~Metastatic ca involving lungs, rt scapula, rt humerus, lt. arteries~~

Due to ~~Ca ... pulmonary congestion & edema~~

Due to Immediate Cause of Death: Sarcoma, Osteogenic, Scapula, with metastasis

DURATION

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results ~~See above~~ Autopsy findings confirmed above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

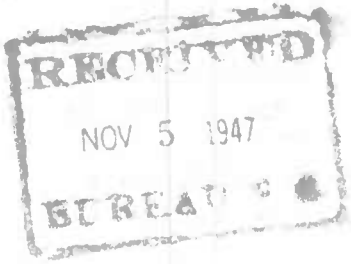
Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE H. B. Eisberg H.B.EISBERG, CDR MC USN M. D. or other

Address USNH, Bethesda, Md. Date signed 10-30-47

~~For~~ authorization to change cause of death see letter, ~~from~~ Dr. Eisberg ~~requested the change~~, on Nov. 7, 1947. ams.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

182

09166

CERTIFICATE OF DEATH

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The date of marriage is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo

Hospital, Institution, or street address where death occurred:

204 Flower ave

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Monty

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 204 Flower ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Denise Lynn Brand

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 23 1947

8. AGE: Years | Months: 1 | Days: 25 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Takoma Park Md

(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: Duane C. Brand

FATHER — 13. Birthplace: New Hampton Iowa

MOTHER — 14. Maiden name: Strieg Keegan

MOTHER — 15. Birthplace: Ft. Wayne Ind.

16. Informant: Duane C Brand

Address: 204 Flower ave Takoma Pk Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 20 1947 (month) (day) (year)

Cemetery or crematory: Forest Park Memorial Cemetery

Location: Riggs Road

18. Funeral director: Arthur J. Stevens

Address: 25th & Carroll St NW Takoma Park D.C.

19. Oct 20 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 18 1947, at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 16 1947 to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Asphyxia due to strangulation	5 min
Due to accident	Instant
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accidental Date of 10-18-47

Where did injury occur? Takoma Park (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?) home

Means of injury strangulation Injured at work? no

23. SIGNATURE: Frank J. Bronhaus M.D.

Address: Gaithersburg Md Date signed 10-18-47

09167

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

161c

CERTIFICATE OF DEATH

Reg. Diat. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital Inc.

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Howard

City or town Dayton
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Linda Diane Brown

3. (b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Female	White	Single

8.(b) Name of husband or wife

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 2, 1947

8. AGE: Years | Months | Days: 2 | If less than one day: ..... hrs. ..... min.

9. Birthplace Olney, Montgomery Co., Md.
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name Allen Miller Brown

13. Birthplace Dayton, Maryland

MOTHER 14. Maiden name Estella Mae Lucas

15. Birthplace Highland, Maryland

16. Informant Hospital records.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-4-47 (month) (day) (year)

Cemetery or crematory Mt. Zion Cemetery

Location Highland, Md.

18. Funeral director F. C. Higgins & Thorn

Address Ellicott City, Md.

19. Oct. 4 1947 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 1947, at 5 20/A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 2 1947, to October 4 1947

and that I last saw him alive on October 4 1947

Immediate cause of death	DURATION
Erythroblastosis Fetalis	2 days
Due to: RH incompatibility of parents	?
Due to:	
Other conditions:	

(include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did Injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles S. Whitaker M.D.
M. D. or other

Address Clarksville, Md. Date signed 10-4-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09168

51 b-x

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: TAKOMA PARK, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 yrs.

Hospital, Institution, or street address where death occurred:
WASHINGTON SAN. + HOSPITAL

How long in hospital or institution? 30 hrs. 10 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: MONTGOMERY

City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)

Street No. 213 BUFFALO AVE
(If rural, give LOCATION)

2.(a) If veteran, name war: MD

3.(a) FULL NAME: BRYANT, THEODORE KELLER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: MARY BRYANT

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): July 11, 1875

8. AGE:

Years	Months	Days	If less than one day
72	2	23	..... hrs. ..... min.

9. Birthplace: Ethicur, New York
(Town, county, and state)

10. Usual occupation: Retired lawyer

11. Industry or business

FATHER
12. Name: Benjamin Bryant
13. Birthplace: New York ?

MOTHER
14. Maiden name: Margaret Buchanan (?)
15. Birthplace: Dryden N.Y.

16. Informant: Mrs. G.A. Wahlstrom
Address: 213 Buffalo Ave. Takoma Pk Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof ..... (month) (day) (year)

Cemetery or crematory: Lakeview Cemetery

Location: Ithaca - N.Y.

18. Funeral director: WALTERS FUNERAL HOME

Address: 254 - Carroll St. Takoma Park

19. Oct 4 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 4 1947, at 6.55 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946 to Oct 4 1947 and that I last saw h.. alive on Oct 4 1947

Immediate cause of death	DURATION
Auricular Fibrillation with Cardiac Failure	
Due to Bronchopneumonia	
Due to Cachexia associated with Carcinoma of Prostate	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Dean D Harding M.D. M. D. or other

Address: 113 Carroll St NW Wash D.C. Date signed: 10-4-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 L

09169

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 9-15-47

Hospital, institution, or street address where death occurred: Suburban Hosp.
8600 Old Georgetown Rd - Bethesda Md.

How long in hospital or institution? Since 9-15-47

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town 7120 Radnor Rd.,
(If outside city or town limits, write RURAL and give nearest town)

Street No. Bethesda, Md.,
(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME Mrs Orpha K. Burchfield

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband or wife William E Burchfield 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1872

8. AGE: Years	Months	Days	If less than one day
74	10	13	..... hrs. ..... min.

9. Birthplace California
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER
12. Name H. Street
13. Birthplace New Haven, Conn.,

MOTHER
14. Maiden name Emily Haslam
15. Birthplace England

16. Informant Hospital Records
Address Bethesda - Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Oct. 2, 1947 (month) (day) (year)

Cemetery or crematory Cedar Hill Crematory

Location Washington, D. C.

18. Funeral director Wm. Rawson Funeral Home

Address Bethesda, Maryland

19. 10/1 (Date rec'd by registrar) 1947 Mn E Ihas Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-1 1947, at 3:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 May 1947, to 1 Oct. 1947
and that I last saw h.. alive on 1 Oct. 1947, 19.....

Immediate cause of death	DURATION
Cardiac Failure	2 days.
Due to Carcinoma of Hepatic flexure of colon	one yr.?
Due to Metastasis to Liver and Lung	5 mo.?
Other conditions Arteriosclerosis - Generalized. (Include pregnancy within 3 months of death)	

Major findings of operations Carcinoma of colon & metastasis - Date of op. 9/21/47

Autopsy results ....as above....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John G. Ball M. D.
M. D. or other

Address 7936 Hampton Blvd, Norfolk, Va. Date signed 10-4-47

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

09170

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington Sanitarium & Hospital

How long in hospital or institution? 5 months - 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Springs

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8712 Colesville Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Carlin, Mrs Nora M

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife Mr. James J Carlin

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 2, 1876

8. AGE: Years	Months	Days	If less than one day
(70) 70	10	13	12 hrs. ..... min.

9. Birthplace Ithaca, New York (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own

FATHER 12. Name William J Sullivan

13. Birthplace Oswego, New York

MOTHER 14. Maiden name Katherine Eccley

15. Birthplace Ithaca, New York

16. Informant Washington Sanitarium & Hospital Records

Address Takoma Park, Maryland

17. Removal & Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 5, 1947 (month) (day) (year)

Cemetery ~~or crematory~~ Calvary

Location Ithaca, New York

18. Funeral director Warner E. Pumphrey

Address Silver Spring, Md.

19. Oct 4 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 1947 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1947 to October 4 1947 and that I last saw her alive on October 3 1947

	DURATION
Immediate cause of death Cerebral arteriosclerosis with multiple infarcts (cerebral)	7 months
Due to Generalized arteriosclerosis	2 years
Due to	
Other conditions Hypertension, heart disease Diabetes mellitus	5 years 8 months

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None performed.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Aaron H. Traum M.D. M. D. or other

Address 8237 Georgia Ave, Silver Spring, Md. Date signed Oct 4, 1947

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09171

30g

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1405 3rd St., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

CARSON, John Benjamin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	married

6.(b) Name of husband or wife: Della Carson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 11, 1892

8. AGE: Years	Months	Days	If less than one day
55	8	20	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Labor

11. Industry or business

FATHER

12. Name: CARSON, William dec.

13. Birthplace: Md.

MOTHER

14. Maiden name: AYERS, Lucinda dec.

15. Birthplace: Washington, D. C.

16. Informant: wife: Mrs. Della Carson

Address: 1405 3rd St., N. W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Malvan & Schey

Address: 424 R St., N. W., Wash., D.C.

19. 10-31 19 47 (Date rec'd by registrar)

Mary C. Patterson
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31 19 47 at 6:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 11 19 47 to 31 October 19 47 and that I last saw him alive on 31 October 19 47

Immediate cause of death	DURATION
Uremia & Cardiac failure	
Due to Hypertensive Cardiovascular disease	
Due to Cerebral accident	
Renal failure	
Other conditions Syphilis	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: D. E. Billman Lt. MC USNR

D. E. BILLMAN, Lt. (jg) MC USNR

Address: USNH BETHESDA, Md. Date signed: 10-31-47

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09172

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs.

Hospital, institution, or street address where death occurred:
5601 River Rd. Bethesda, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6501 River Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Mary J. Churchill

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George M. Churchill

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): May 1, 1876

8. AGE: Years	Months	Days	If less than one day
71	5	22	....hrs. ....min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Louie C. Solyomdeantalfa

13. Birthplace: Poland

MOTHER — 14. Maiden name: Sarah J. Good

15. Birthplace: Washington, D.C.

16. Informant: George M. Churchill

Address: 5601 River Rd., Bethesda, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 10/25/47 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Maryland

18. Funeral director: Wm Reuben Humphrey

Address: 7557 Wisconsin Ave., Bethesda, Md.

19. 10/25 (Date rec'd by registrar) 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 23 1947 at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....
Dep med exam case,
and that I last saw h.... alive on ....19....

Immediate cause of death: Coronary occlusion — DURATION: due to sudden

Due to: — DURATION:

Due to: — DURATION:

Other conditions: — DURATION:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Broschart M.D.
Dep med Exam M. D. or other

Address: Gaithersburg md Date signed 10-23-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

09173

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:
County: Montgomery
City or town: Brinklow, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Brinklow, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Robert A. Cole

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	A.A.	Married

6.(b) Name of husband or wife: Mary E. Cole
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 6, 1896

8. AGE: Years	Months	Days	If less than one day
51			hrs. min.

9. Birthplace: Maryland.
(Town, county, and state)
10. Usual occupation: Bus Driver
11. Industry or business:

FATHER
12. Name: John F. Cole
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Perry Anna Budd
15. Birthplace: Maryland.

16. Informant: Mary E. Cole
Address: Brinklow, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 9, 1947 (month) (day) (year)
Cemetery or crematory: Arlington Memorial Cemetery
Location: Washington, D.C.

18. Funeral director: B. L. Snouden
Address: Rockville, Md.

19. Oct 8 1947 Gertrude B. Isaac Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 4th 1947, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep med. Exam case, 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank J. Brochard M.D. M. D. or other
Address: Gaithersburg Md. Date signed 10-4-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1


OCT 13 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1176

09175

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery.

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? nine days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6000 2nd St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW2

3.(a) FULL NAME: CONNELLY, Bernard Michael

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Elizabeth R. Connelly

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 12, 1900

8. AGE: Years	Months	Days	If less than one day
46	10	26	hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Bureau of Engraving

11. Industry or business:

FATHER
12. Name: CONNELLY, James H. dec.
13. Birthplace: N.Y.

MOTHER
14. Maiden name: CONNELLY, Ellen
15. Birthplace: N.Y.

16. Informant: wife: Mrs. Elizabeth R. Connelly
Address: 6000 2nd St., N. W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 10-10-47 (month) (day) (year)

Cemetery or crematory: Mt Olivet

Location: Maryland

18. Funeral director: James T. Ryan

Address: 317 Penn., Ave., S.E., Wash. D.C.

19. 10-8 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 October 1947, at 2:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 29 1947, to 8 Oct. 1947 and that I last saw h... im alive on 8 Oct. 1947

	DURATION
Immediate cause of death: Uremia and massive gastro intestinal hemorrhage and transfusion reaction	10 days.
Due to: Duodenal Ulcer	8 years.
Due to: 123:2 132.2	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

SF Kaufman

23. SIGNATURE: S. F. KAUFMAN, Lt. JG MC USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 10-8-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83d

09174

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery Co.

City or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since Sept. 27, 1947

Hospital, Institution, or street address where death occurred: Suburban Hosp Bethesda Md.

How long in hospital or institution? since Sept. 27, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1024 Moyes Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Clara Cook

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband or wife Theodore Cook

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 19, 1871

8. AGE: Years	Months	Days	If less than one day
76	2	20	..... hrs. ..... min.

9. Birthplace Philadelphia Pennsylvania
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

FATHER
12. Name F. Parker
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Louisa Robb
15. Birthplace Pennsylvania

16. Informant Ruth P. Giffen

Address 1024 Moyes Drive Silver Spring Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/11/47 (month) (day) (year)

Cemetery or crematory Ft Lincoln Cem

Location

18. Funeral director The S.E. Kiser Co

Address 2901 14th St N.W. D.C.

19. 10/9 1947 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9 1947 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 Sept 1947 to 9 Oct 1947 and that I last saw h[illegible] alive on 8 Oct 1947

Immediate cause of death	DURATION
Bronchopneumonia	17 days
Due to	
Due to	
Other conditions Arteriosclerosis -	20 yrs
old Cerebral Hemiplegia	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W S Murphy M.D. M. D. or other

Address Rockville Md Date signed 9 Oct 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

09176

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Capitol View

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 yrs

Hospital, institution, or street address where death occurred:

8 Lee St.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Monty.

City or town: Capitol View

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 8 Lee St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Lena DeS Crawford

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	W	widow

6.(b) Name of husband or wife: Wm. W. Crawford

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept 8 1855

8. AGE:

Years	Months	Days	If less than one day
92	0	23	..... hrs. ..... min.

9. Birthplace: Ironton, Ohio (Town, county, and state)

10. Usual occupation: housework

11. Industry or business: —

FATHER

12. Name: Wm M. Bolles

13. Birthplace: Conn.

MOTHER

14. Maiden name: Amarylla Long

15. Birthplace: Va

16. Informant: Mary Crawford

Address: 8 Lee St. Capitol View Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 2, 1947 (month) (day) (year)

Cemetery or crematory: Portsmouth, Ohio

Location: Portsmouth, Ohio

18. Funeral director: Ashe & N. Kinsella

Address: 290 [illegible]

19. Oct 2 1947 (Date rec'd by registrar) Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 1 1947, at 5:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1947 Med. Exam Case, to ..... 19..., and that I last saw h... alive on ..... 19...

Immediate cause of death: Carcinoma of face — DURATION: 14 mo.

Due to: .....

Due to: .....

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operation: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Brockhart M. D.

Dec 1947 Med Exam M. D. or other

Address: Hagerstown Md. Date signed: 10-6-47

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age, shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

108

09177

FILM NO. G 11 NOV 12 1947

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3040 R St., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3. (a) FULL NAME: CULP, Everett Alexander

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 31, 1894

8. AGE: Years	Months	Days	If less than one day
53 ~~53~~	8	29	hrs. min.

9. Birthplace: Texas (Town, county, and state)

10. Usual occupation: Keeper, Washington Zoo

11. Industry or business:

FATHER

12. Name: CULP, John K.

13. Birthplace: Miss.

MOTHER

14. Maiden name: CORRUTH, L.

15. Birthplace: Miss.

16. Informant: daughter: Miss Doris N. Culp

Address: 3040 R St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 11-1-47 (month) (day) (year)

Cemetery or crematory: Washington Memorial

Location: Hyattsville, Md.

18. Funeral director: W. W. CHAMBERS

Address: Georgetown, D.C.

19. 10-30 1947 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30 1947 at 3:20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 20 1947 to October 30 1947 and that I last saw him alive on 30 October 1947

Immediate cause of death	DURATION
Bronchopneumonia	12 days
Due to: Bronchiectasis	duly.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Broncho to Lobar Pneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. L. FLECK, Lt. MC USN

M. D. or other

Address: USNH Bethesda, Md. Date signed: 10-30-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

09178

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 49 Elm Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war — — —

3.(a) FULL NAME Mrs. Lynde May Damon

3.(b) Social Security Number — — —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife George Frank Damon
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 20, 1865

8. AGE: Years	Months	Days	If less than one day
82	4	15	..... hrs. ..... min.

9. Birthplace Kirtland, Lake Co., Ohio
(Town, county, and state)
10. Usual occupation House wife
11. Industry or business

FATHER
12. Name Samuel Morse Whiting
13. Birthplace Kirtland, Ohio

MOTHER
14. Maiden name Frances Tryon
15. Birthplace Painesville, Ohio

16. Informant Mrs. J. B. Allen, daughter
Address 49 Elm Ave., Takoma Park, Md.

17. Cremation
(Burial, cremation, or removal. Which?)
Date thereof Oct. 7 1948
(month) (day) (year)
~~Cemetery or~~ crematory CEDAR HILL
Location Suitland-Prince Georges Co. Md.

18. Funeral director Warren E. Pumphrey
Address Silver Spring, Md.

19. 10/7 1947 Wm E. Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6 1947, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 6 1947 to 6 Oct. 1947 and that I last saw her alive on 5 Oct. 1947

Immediate cause of death	DURATION
Coronary Artery Disease	7 Days.
Due to Senile Arteriosclerosis	8 or 9 years
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE G. B. Allen M.D.
M. D. or other
Address Takoma Park, Md Date signed 6 Oct. 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1246

CERTIFICATE OF DEATH

09179 216

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH: Montgomery

County .....

City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 27 days

Hospital, Institution, or street address where death occurred:
USNH Bethesda, Md.

How long in hospital or institution? 4 months, 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Cottage City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3806 Park Wood Street
(If rurel, give LOCATION)

2.(a) If veteran, name war W. W. I

3.(a) FULL NAME DECKER, Seeley Alexander

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	married

6.(b) Name of husband or wife Vera Decker B.(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 14 September 1897

8. AGE: Years	Months	Days	If less than one day
50	1	10	....hrs. ....min.

9. Birthplace New York
(Town, county, and state)

10. Usual occupation Cook

11. Industry or business Rustic Cabin

FATHER 12. Name Walter Decker

13. Birthplace New York, deceased

MOTHER 14. Maiden name Mary Scott

15. Birthplace New York, deceased

16. Informant Wife: Mrs. Vera Decker

Address 3806 Park Wood St., Cottage City, Md.

17. burial Date thereof 10-29-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington, Virginia

18. Funeral director W. W. Chambers Co. M.P.

Address 5801 Cleveland Ave., Riverdale, M.

19. 10-25 19 47 Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT 24 1947 19.... at 11:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-29- 19 47, to 10-24- 19 47 and that I last saw him alive on 10-24- 19 47

Immediate cause of death	DURATION
Massive Gastro intestinal Hemorrhage from Esophageal varix.	5 months advanced
Due to Cirrhosis of Liver	
Due to	
Other conditions Cholemia	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE F. E. WETZEL, LT MC USN
M. D. or other

Address USNH Bethesda, Md. Date signed OCT 25 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 f

09189

Reg. Dist. No. Y 14

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~XXXXXXXXXXXX~~ street address where death occurred:
830 Gist Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland Couety Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 830 Gist Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME LOTTIE ROBERTA DEEBLE

3.(b) Social Security Number — — —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband ~~XXX~~ Henry A.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 12th. 1883

8. AGE: Years	Months	Days	If less than one day
64	8	10	..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Francis Nevitt
13. Birthplace Maryland

MOTHER
14. Maiden name Roberta Burch
15. Birthplace Maryland

16. Informant Mr. Henry A. Deeble

Address 830 Gist Ave. Silver Spring.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 23rd. '47 (month) (day) (year)

Cemetery ~~XXXXX~~ Fort Lincoln

Location Pr. Geo's Co., Maryland.

18. Funeral director Warner E. Pumphrey

Address Silver Spring, Md.

19. Oct 27 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1947, at 2100 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1939 to Oct 21 1947

and that I last saw him alive on Oct 21 1947

Immediate cause of death	DURATION
Carcinoma Ascending colon	2 yrs.
With metastasis to Liver	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma Ascending colon

Date of op. 1944.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE W. B. Vardup M.D. M. D., or other

Address 943 Bonifant St Date signed 10-22-47

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

09181

Reg. Diat. No. 211

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Damascus mnp
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Damascus. md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Marguerite Langley Dutton

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 14-1864
8. AGE: Years: 83 Months: 2 Days: 21 If less than one day: hrs. min.
9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: none
11. Industry or business: none
FATHER 12. Name: Samuel J Langley
13. Birthplace: Washington D.C.
MOTHER 14. Maiden name: Mary C Tilton Langley
15. Birthplace: Unknown
16. Informant: Harold H. Dutton
Address: Washington D C
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 8-1947 (month) (day) (year)
Cemetery or crematory: Rock Creek.
Location: Washington D.C.
18. Funeral director: Roy W. Barker
Address: Laytonsville md
19. Oct 6 1947 (Date rec'd by registrar) Della N. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 5 1947 at 3:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15, 1946, to October 5 1947
and that I last saw h. E.R. alive on October 5 1947

	DURATION
Immediate cause of death: Arteriosclerotic cardio vascular disease.	1 Year
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James P. Kerr M.D.
M. D. or other
Address: Damascus, Md. Date signed: 10/6/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09182

13 la

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 days

Hospital, Institution, or street address where death occurred:
The Montgomery County General Hospital 24
47 days.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Laytonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Dr. Vernon H. Dyson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widowed.

6.(b) Name of husband or wife Lena Dyson

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 24 1866

8. AGE: Years	Months	Days	If less than one day
81	9	10	— hrs. — min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Physician

11. Industry or business

FATHER 12. Name Benjamin Dyson

13. Birthplace Maryland

MOTHER 14. Maiden name Kathryn Pyles

15. Birthplace Maryland

16. Informant Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 7 1947 (month) (day) (year)

Cemetery or crematory Monocacy

Location Beallsville Md

18. Funeral director Roy W. Barker

Address Laytonsville Md

19. Oct. 6 1947 (Date rec'd by registrar) Gertrude B. Lawlor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1947, at 7:35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19 1947 to October 5 1947 and that I last saw him alive on October 5 1947

Immediate cause of death	DURATION
Uraemia	4 days.
Due to Chronic interstitial nephritis	5 years.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D.

Address Sandy Spring, Md Date signed 10/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09183

Reg. Dist. No. 716

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs.

Hospital, institution, or street address where death occurred: 105 Chevy Chase Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase, Maryland (If outside city or town limits, write RURAL and give nearest town)

Street No. 105 Chevy Chase Drive (If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: ELLIS, James R.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Henrietta S.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 10, 1877

8. AGE: Years	Months	Days	If less than one day
69	11	3	..... hrs. ..... min.

9. Birthplace: Marion Co., Missouri (Town, county, and state)

10. Usual occupation: Retired Civil Eng. U.S. Govt

11. Industry or business

FATHER — 12. Name: William Ellis

13. Birthplace: Kentucky

MOTHER — 14. Maiden name: Mary James

15. Birthplace: Marion Co. Missouri

16. Informant: Mr. Walter Sacks

Address: 105 Chevy Chase Drive, Chevy Chase, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/15/47 (month) (day) (year)

Cemetery or crematory: Prospect Hill Cemetery

Location: Washington, D. C.

18. Funeral director: Wm Reuben Humphreys

Address: 7557 Wis. Ave. Bethesda, Maryland

19. 10/14 19 47 (Date rec'd by registrar) Mrs E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 13, 1947 at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 13 1947, to Oct. 13, 1947.

and that I last saw h-- alive on Oct. 13, 1947

Immediate cause of death	DURATION
Generalized Carcinomatosis	7 mos
Due to Carcinoma of Lung	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Left Lung Date of op. Mar 28, 47.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Emil G. Bauersfeld M.D. M. D. or other

Address: Bethesda, Md. Date signed 10/13/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09184

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R. 7, D. #2
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: ~~Fred Engler~~ FRED HERMAN ENGLER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 11, 1895.

8. AGE: Years: 52 | Months: 1 | Days: 6 | If less than one day: hrs. min.

9. Birthplace: E. Troy, Wisc. (Town, county, and state)
10. Usual occupation: Glassblower
11. Industry or business

FATHER
12. Name: Herman Engler
13. Birthplace: Germany

MOTHER
14. Maiden name: Anna Wörhlin
15. Birthplace: Germany

16. Informant: patient
Address

17. Removal & Burial (Burial, cremation, or removal. Which?) Date thereof: 10-19-1947 (month) (day) (year)
Cemetery or crematory: Kingfisher Cemetery
Location: Kingfisher, Kingfisher Co. Okla.
18. Funeral director: Harvest Memorial
Address: Silver Spring, Maryland

19. 10/21/1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 17, 1947, at 1:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1936 to Oct. 17 1947 and that I last saw him alive on Oct 17, 1947

Immediate cause of death	DURATION
Gastric hemorrhage	3 weeks
Due to: Gastric ulcer	
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gilbert B. Lude M. D. or other
Address: 3900 Military rd. Date signed: 10-17-1947

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

Silver Spg Rt 2

Bro Edw R. & Rudolph
of Kingfisher Okla

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09185

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~XXXXXXXXX~~ or street address where death occurred:
116 Hamilton Ave.,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 116 Hamilton Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: FREDERICK MANNING FAIRFAX

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Ann

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 18th. 1904

8. AGE: Years	Months	Days	If less than one day
42	11	13	..... hrs. ..... min.

9. Birthplace: Fairfax, Va.
(Town, county, and state)

10. Usual occupation: Employee, Treasury Dep't.

11. Industry or business: U. S. Goverment

FATHER
12. Name: Archie Franklin Fairfax
13. Birthplace: Fairfax, Va.

MOTHER
14. Maiden name: Lou Emma Davis
15. Birthplace: Fairfax, Va.

16. Informant: Mrs. Ann Fairfax,
Address: 116 Hamilton Ave. Silver Spring

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-4-1947 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Prince Georges Co. Maryland.

18. Funeral director: Warner E. Pumphrey
Address: Silver Spring, Md.

19. Oct 2 19 47 (Date rec'd by registrar) Josephine McSchaffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 1, 1947, at 6 15/A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-25-1945 to 10-1-1947 and that I last saw h. alive on 10-1-1947

Immediate cause of death	DURATION
Acute coronary occlusion	45 minutes
Due to: Essential hypertension	2 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

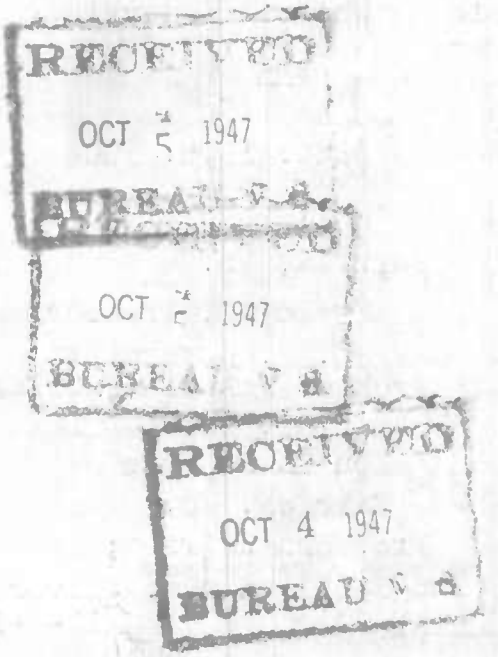
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W. Schumaker M. D. or other
Address: 8005 Woodbury Drive, Silver Spring, Md. Date signed: 10/1/47

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46a X

09186

CERTIFICATE OF DEATH

Reg. Dist. No. Y14

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
2008 Lansdowne Way
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2008 Lansdowne Way
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: WILLIAM G. FENNEL

3.(b) Social Security Number: 207-10-4447

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Anna C.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 19th. 1879

8. AGE: Years	Months	Days	If less than one day
67	11	18	hrs. min.

9. Birthplace: Heckersville, Pa. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business
12. FATHER — Name: William Fennel
13. FATHER — Birthplace: Heckersville, Pa.
14. MOTHER — Maiden name: Anna M. Evans
15. MOTHER — Birthplace: Minersville, Pa.
16. Informant: Mrs. Anna C. Fennel
Address: 2008 Lansdowne Way
17. Removal (Burial, cremation, or removal. Which?) Date thereof 10-7-1947 (month) (day) (year)
Cemetery or crematory
Location: Allentown, Lehigh Co. Pa.
18. Funeral director: Wanes E Pumphrey.
Address: Silver Spring, Md.
19. Oct 7 1947 (Date rec'd by registrar) Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 7 1947 at 2 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1947 to Oct 7 1947 and that I last saw h[illegible]ive on Sept 27, 1947

	DURATION
Immediate cause of death: Carcinoma of [illegible] esophagus [illegible] Metastasis	
Due to: [illegible]	
Due to: [illegible]	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of esophagus. Date of op. July 12, 1947
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. E Ball MD M. D. or other
Address: 2835 Eastern Ave Baltimore Md Date signed: Oct 7 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09187

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, Institution, or street address where death occurred:
6613 Strathmore Street,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6613 Strathmore St.,
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: Dr. Milburn M. Fowler

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Marcia W. Fowler

6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): September 21, 1891

8. AGE: Years	Months	Days	If less than one day
56	1	6	..... hrs. ..... min.

9. Birthplace: Maine
(Town, county, and state)

10. Usual occupation: Assistant Medical Director

11. Industry or business: Dental Service, Veterans Ad.

FATHER
12. Name: Nathan Fowler
13. Birthplace: Maine

MOTHER
14. Maiden name: Emma Dennett
15. Birthplace: Maine

16. Informant: Mrs. Marcia W. Fowler
Address: 6613 Strathmore St., Ch. Ch. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/29/47 (month) (day) (year)

Cemetery or crematory: Arlington National Cem.

Location: Arlington, Virginia

18. Funeral director: Wm. Reuben Pumphrey

Address: 7557 Wis. Ave. Bethesda, Maryland

19. 10/28/47 (Date rec'd by registrar) Wm E Johns Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 27th, 1947 at 5:30A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: DEP. MED. EXAM. CASE — DURATION

Coronary Occlusion — Died Suddenly

Due to.....

Due to.....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Brockard M. D.
Dep. Med. Exam. M. D. or other

Address: Gaithersburg, Md. Date signed: 10/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

09188

CERTIFICATE OF DEATH

Reg. Dist. No. 2-11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery Co

City or town: Clarksburg Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? All his life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Clarksburg Md Rfd 2

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Arthur M Pilson

3.(b) Social Security Number: 212-20-1742

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Married

6.(b) Name of husband or wife: Ella M Pilson

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Jan. 18 1884

8. AGE: Years	Months	Days	If less than one day
63	9	10	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER — 12. Name: Rufus Pilson

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Alice Williams

MOTHER — 15. Birthplace: Maryland

16. Informant: Ella M Pilson

Address: Clarksburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 31 1947 (month) (day) (year)

Cemetery or crematory: Johns Wesley

Location: Clarksburg Md

18. Funeral director: Roy W Barber

Address: Gaithersburg Md

19. Oct 30 1947 (Date rec'd by registrar) Della V Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 28, 1947 at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 14 1941 to October 28 1947

and that I last saw him alive on October 27 1947

Immediate cause of death: Cerebral Hemorrhage — DURATION: 5 days

Due to: Arteriosclerotic cardiovascular disease — 10 years

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James P. Kerr M.D. M. D. or other

Address: Damascus, Md. Date signed 10/30/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 f K

09189

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park 12, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 days.

Hospital, institution, or, street address where death occurred:

Washington San & Hosp.

How long in hospital or institution? 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: New York County:

City or town: New York City.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 111 John St.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME

Mr. Walter Gouda.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Ada Kathleen Gouda

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 29, 1864 — London, England

8. AGE:

Years	Months	Days	If less than one day
83	6	13	hrs. min.

9. Birthplace: London, England (Town, county, and state)

10. Usual occupation: Insurance Broker

11. Industry or business: " " "

FATHER — 12. Name: Arnold Gouda

13. Birthplace: Amsterdam

MOTHER — 14. Maiden name: Eliza Jane Browning

15. Birthplace: Amsterdam

16. Informant: London, England

Address

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Oct 7, 1947 (month) (day) (year)

Cemetery or crematory: Cedar Hill Crematory

Location: Cedar Hill Cemetery

18. Funeral director: Arthur J. Walters

Address: 254 Carroll Ave.

19. Oct 7 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7 1947, at 9:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 6, 1947 to October 7, 1947 and that I last saw h.i.m. alive on October 6, 1947

Immediate cause of death	DURATION
Metastatic Carcinoma to liver, lymph nodes	6-10 mos
Due to: + lung Cylindrical cell Carcinoma of	1½ yrs.
Due to: sigmoid ?	
Other conditions: Bilateral lipomas in axillae	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Lionel Roth M.D. M. D. or other

Address: Washington San & Hosp. Date signed: 10/7/47

T. P. Md.

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

09190

CERTIFICATE OF DEATH

Reg. Diat. No. 414

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montg
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 hrs.
Hospital, Institution, or street address where death occurred: 2003 GRACE CHURCH RD
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2001 Grace Church Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Ray Cleveland Gooding

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Nellie May Gooding
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 1, 1888

8. AGE: Years	Months	Days	If less than one day
59	2	21	..... hrs. ..... min.

9. Birthplace: Madison Va.
(Town, county, and state)
10. Usual occupation: Superintendent of Mail
11. Industry or business: U.S. Post Off.
FATHER 12. Name: James H Gooding
13. Birthplace: Madison, Va
MOTHER 14. Maiden name: Eliza Davis
15. Birthplace: Va.
16. Informant: Ed. L. Gooding
Address: 9512 Fenwick St S.S. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 25-1947 (month) (day) (year)
Cemetery or crematory: Glenwood.
Location: Washington D.C.
18. Funeral director: Walter E Pumphrey
Address: Silver Spring Md.
19. Oct 23 1947 (Date rec'd by registrar) Josephine M. Schaefer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 22 1947, at 5 50/60 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 5 1947, to Oct 10 1947
and that I last saw him alive on Oct 10 1947.

Immediate cause of death	DURATION
Cerebral Hemorrhage.	1 yr. 14 days, 1 mo 10 days
Due to	
Due to Hypertension Vascular Collapse	2 days.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Howard Thorne Ford M. D. or other
Address: Takoma Park, Md. Date signed 10/22/47

09191

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47cK

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 425 M St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war...: WW1

3.(a) FULL NAME: GORDON, Walter

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	married

6.(b) Name of husband or wife: Mary Gordon

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): Dec 25, 1898

8. AGE: Years	Months	Days	If less than one day
48	9	7	... hrs. ... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Naval Gun Factory

11. Industry or business:

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: wife; Mrs. Mary Gordon
Address: 425 M St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 10-8-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: John T. Rhines & Co. W.S.

Address: 3rd & Eye St., S. W., Wash., D.C.

19. 10-2 19 47 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 Oct. 19 47, at 7:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 9 19 47, to 2 Oct. 19 47 and that I last saw him alive on 2 October 19 47

Immediate cause of death	DURATION
Bronchogenic Carcinoma with metastasis	1 yr ?
Due to	
Due to	
Other conditions Cerebral thrombosis; atelectasis R. & L. upper lobes (Include pregnancy within 3 months of death)	2 mo. ?

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ...

Means of injury: ... Injured at work?

23. SIGNATURE H. L. C. STEVENS, Jr. Lt. JG MC USNR
M.D. or other

Address: USNH Bethesda, Md. Date signed 10-2-47

H. L. C. Stevens Jr.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09192

50 K

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:
Lux Lane, Bethesda, Md. (Residence)

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Lux Lane
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: ********* MARY MARGARET DOVE GRAVES

3.(b) Social Security Number: ********** None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: E. Charlton Graves, 2nd

6.(c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): February 20, 1916

8. AGE: Years	Months	Days	If less than one day
31	7	22	..... hrs. ..... min.

9. Birthplace: Iowa
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Frank F. Dove
13. Birthplace: New York

MOTHER
14. Maiden name: Florence Smith
15. Birthplace: New York

16. Informant: E. Charlton Graves, 2nd
Address: Lux Lane, Bethesda, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/15/47 (month) (day) (year)

Cemetery or crematory: Rock Creek Cemetery

Location: Washington, D.C.

18. Funeral director: Wm Reuben Pumphrey

Address: 7557 Wis. Ave., Bethesda, Maryland

19. 10/13/47 (Date rec'd by Registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/12/1947 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3-10 1947 to 10-12 1947 and that I last saw her alive on 10/10/1947

Immediate cause of death	DURATION
Carcinoma of Breast with diffuse metastasis.	10 mo
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Radical mastectomy - Feb '47 for Ca of Breast. Date of op. 3-Feb 47

Autopsy results: Diffuse carcinomatosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Calvin T. Hoop MD
M.D. or other

Address: Warwick Mem Clinic Washington 1, D.C. Date signed: 10/12/47


RECEIVED
OCT 16 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

09193

Reg. Dist. No. 4/18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Burnt Mans Station Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Fifty years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgom
City or town Rural Etchison Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Joseph Lee Gray

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

B.(b) Name of husband or wife Ettie Burdette
B.(c) If alive, give age Unknown years

7. Birth date of deceased (mo., day, yr.) March 3 - 1866

8. AGE: Years	Months	Days	If less than one day
81	7	22	hrs. min.

9. Birthplace Montgomery Co Md (Town, county, and state)
10. Usual occupation Farming
11. Industry or business Farm Grafs
FATHER 12. Name William Gray
13. Birthplace Montgom Co Md
MOTHER 14. Maiden name Elizabeth Stewart
15. Birthplace Montgom Co Md
16. Informant Graham Gray
Address Gaithersburg Md
17. Burial (Burial, cremation, or removal, which?) Date thereof Oct 27 1947 (month) (day) (year)
Cemetery or crematory W Tabor
Location Etchison Md
18. Funeral director Roy W Barber
Address Poolesville Md
19. 10/27/47 (Date rec'd by registrar) Louis O Bell Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1947, at 12:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 21, 1945, to October 1947
and that I last saw him alive on 1947

Immediate cause of death	DURATION
Arteriosclerotic gangrene of both legs.	2 months
Due to Arteriosclerotic cardiovascular disease.	20 years.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James P. Kerr M.D. M. D. or other
Address Darnestown Md. Date signed 10/27/47

09194

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 516 +

CERTIFICATE OF DEATH

Reg. Dist. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 mts -

Hospital, Institution, or street address where death occurred:
The Montgomery County General Hospital Inc.

How long in hospital or institution? 9 months.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Derwood
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. Near Olney
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Nicholas Ridgely Griffith

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) February 18, 1870

8. AGE:

Years	Months	Days	If less than one day
76	7	16	____ hrs. ____ min.

9. Birthplace Montgomery County, Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Thomas Griffith
13. Birthplace Montgomery County, Md.

MOTHER
14. Maiden name Elizabeth Davis Sinclair
15. Birthplace Talbert County, Md.

16. Informant Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 7 1947 (month) (day) (year)

Cemetery or crematory St. Johns

Location Olney Md

18. Funeral director Booth Barker

Address Gaithersville Md

19. Oct. 6, 1947 (Date rec'd by registrar) Gertrude B. Fowler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1947 at 4:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 4 1947 to October 5 1947 and that I last saw him alive on October 5 1947

Immediate cause of death	DURATION
Carcinomatosis	18 mts.
Due to Carcinoma of prostate	3 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Sandy Spring, Md Date signed 10/5/47


RECEIVED
OCT 13 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 ex

09195

Reg. Dist. No. 314

1. PLACE OF DEATH:

County: Montgomery

City or town: RURAL - Layhill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 yrs.

Hospital, Institution, or street address where death occurred:

—

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Montgomery

City or town: RURAL - Layhill

(If outside city or town limits, write RURAL and give nearest town)

Street No. Bonifant Rd. - Layhill

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME

MARY MOLLY HARRELL

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Wh.	married

6.(b) Name of husband or wife: Chas. I. Harrell

6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): Aug 2, 1871

8. AGE:

Years	Months	Days	If less than one day
76	2	15	....hrs. ....min.

9. Birthplace: Fairfax, Va.

(Town, county, and state)

10. Usual occupation: hswf-

11. Industry or business: —

FATHER

12. Name: Louis Robey

13. Birthplace: Va.

MOTHER

14. Maiden name: Charlotte Kitchen

15. Birthplace: Va.

16. Informant: Mr. C. I. Harrell

Address: Layhill - Silver Spring Rt 1, Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof OCT - 23 - 1947 (month) (day) (year)

Cemetery ~~or crematory~~: DARNESTOWN.

Location: DARNESTOWN - Montg Co. Md

18. Funeral director: Daniel E Pumphrey

Address: SILVER SPRING. Md

19. Oct 21 1947 (Date rec'd by registrar) Josephine M. Schaeffer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 21 1947, at 6:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 23 1947, to October 21 1947

and that I last saw her alive on October 20 1947

Immediate cause of death	DURATION
Carcinoma of Colon	
Due to	
Due to	
Other conditions: Acute cardiac dilitation; Broncho-pneumonia.	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results: ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE: Richard A. Yates M.D.

M.D. or other

Address: RFD #3 Rockville, Md. Date signed 10/21/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09196

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County:
City or town: Alexandria
(If outside city or town limits, write RURAL and give nearest town)
Street No. 300 Evens Lane
(If rural, give LOCATION)
2.(a) If veteran, name war: WWI

3.(a) FULL NAME: HARRISON, Stanley (n)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Katherine Elizabeth Harrison
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 6, 1892

8. AGE: Years	Months	Days	If less than one day
55	9	3	hrs. min.

9. Birthplace: New York (Town, county, and state)
10. Usual occupation: Instrument Maker
11. Industry or business: Naval Observatory

FATHER
12. Name: HARRISON, Julian dec
13. Birthplace: England

MOTHER
14. Maiden name: MICHAM, Mary
15. Birthplace: Mass.

16. Informant: wife: Mrs. K. E. Harrison
Address: 300 Evens Lane, Alexandria, Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 10-13-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: Lee Funeral Home R. M. D.
Address: 4th & Mass., Ave., N.E., Wash., D.C.

19. 10-10 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 19 19 47 at 6:48A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 22 19 47, to 10 Oct. 19 47
and that I last saw h im alive on 10 October 19 47

	DURATION
Immediate cause of death: Uremia	3 da.
Due to: Cerebral Hemorrhage	7 da.
Myocardial Infarct	1½ mo.
Other conditions: Hypostatic Pneumonia (Include pregnancy within 3 months of death)	5 da.

Major findings of operations: Date of op.
Autopsy results: Confirmed Above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. L. C. Stevens Jr. H. L. C. STEVENS, Jr. Lt.JG MC USNR
M. D. or other
Address: USNH Bethesda, Md. Date signed: 10-10-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45 15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

09197

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 26 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 3 months, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2825 27th St., N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW 1

3.(a) FULL NAME: HAVEN, Frederick Francis, VAP

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Emma M. Haven
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 16, 1878

8. AGE: Years	Months	Days	If less than one day
69	2	15	hrs. min.

9. Birthplace: Col. (Town, county, and state)
10. Usual occupation: Retired - Bureau of Engraving
11. Industry or business: Government

FATHER
12. Name: FORD, ---- DD (foster parents)
13. Birthplace: unknown

MOTHER
14. Maiden name: FORD, --- DD
15. Birthplace: unknown

16. Informant: wife: Mrs. Emma M. Haven
Address: 2825 27th St., N.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 10-4-47 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Md.

18. Funeral director: W. W. CHAMBERS
Address: 517 11th St., S.E., Wash., D.C.

19. 10-2 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 October 19 47 at 3:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 June 19 47, to 1 Oct. 19 47 and that I last saw him alive on 1 Oct. 19 47

Immediate cause of death	DURATION
HYPERTENSIVE HEART DISEASE with CONGESTIVE HEART FAILURE	6 MOS.
Due to ARTERIOLO NEPHRO-SCLEROSIS	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: NONE Date of op.
Autopsy results: SAME AS ABOVE
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. B. Bryan
J. B. BRYAN, Lt. JG MCR USNR
M. D. or other
Address: USNH Bethesda, Md. Date signed: 10-2-47

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

09198

95a

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH: 8626 GARFIELD STREET
County: Montgomery
City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months
Hospital, institution, or street address where death occurred: 8626 Garfield St.
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 8626 GARFIELD STREET, BETHESDA, MD.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: MRS. MARY N. HENNIGH

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Mr. Hennigh

6.(c) If alive, give age: dec. years

7. Birth date of deceased (mo., day, yr.): MAY 11th, 1878

MAY 11th, 1878

8. AGE: Years	Months	Days	If less than one day
69	5	14	— hrs. — min.

9. Birthplace: COLUMBUS, OHIO
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: William Niemeier
13. Birthplace: Germany

MOTHER
14. Maiden name: Sophie Voght
15. Birthplace: Unknown

16. Informant: Mr. Vander V. Holcomb
Address: 8626 GARFIELD STREET, BETHESDA, MD.

17. REMOVAL TO WASH. D.C. Date thereof OCTOBER 26/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Hyson & Funeral Home
Location: Washington, D.C.

18. Funeral director: Martin W. Hyson Co.
Address: 1300 N. STREET, N.W. WASHINGTON, D.C.

19. Oct 26th 1947 Mrs E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCTOBER 25th, 1947 at 5:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 25 1947 to October 25 1947 and that I last saw her alive on October 25 1947

Immediate cause of death	DURATION
Heart Block, complete, Organic	6 MOS.
Due to	
Due to	
Other conditions: Hypertension, Vascular	20 years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George B. Patrick, Jr., M.D.
M. D. or other
Address: 8700 Colesville Rd. Silver Spring, Md. Date signed Oct 26, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09199

47CX

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural) (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 6 days
Hospital, institution, or street address where death occurred: US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 1 month, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: ~~D.C.~~ Md. County: P. Geo.
City or town: Washington Suitland (If outside city or town limits, write RURAL and give nearest town)
Street No. 4610 Lewis Avenue, S.E. (If rural, give LOCATION)
2.(a) If veteran, name war: WW2 ✓

3.(a) FULL NAME: HILLIARD, Holton Herman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Nell Hilliard
6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): May 7, 1906

8. AGE: Years	Months	Days	If less than one day
41	5	8	hrs. min.

9. Birthplace: N.C. (Town, county, and state)
10. Usual occupation: Service Station Operator
11. Industry or business:

FATHER
12. Name: HILLIARD, Thomas Hampton dec.
13. Birthplace: N.C.

MOTHER
14. Maiden name: MALLARD, Elizabeth
15. Birthplace: N.C.

16. Informant: wife: Mrs. Nell Hilliard
Address: 4610 Lewis Ave., S.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 10-20-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS, L.D.
Address: 517 11th St., S.E., Wash., D.C.

19. 10-16 19 47 Mary Charlotte Smith (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 October 19 47 at 10:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Sept 19 47 to 15 October 19 47 and that I last saw h... im alive on 15 October 19 47

Immediate cause of death	DURATION
Carcinoma, metastatic	Unkn
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: Bronchogenic Carcinoma
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. L. FLECK, Lt MC USN (M. D. or other)
Address: USNH Bethesda, Md. Date signed: 10-16-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09200

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 413 Hamilton St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME: HOFFMASTER, Carney Harry Lester

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Agnes O'Donnell Hoffmaster

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): February 21, 1895

8. AGE: Years	Months	Days	If less than one day
52	7	24	..... hrs. ..... min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Retired from Bureau of Census

11. Industry or business: Government

FATHER
12. Name: HOFFMASTER, Benjamin F. dec.
13. Birthplace: Md.

MOTHER
14. Maiden name: GRICE, Margaret
15. Birthplace: Md.

16. Informant: wife: Mrs. Agnes O'D. Hoffmaster
Address: 413 Hamilton St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 10-17-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS

Address: 1400 Chapin St., N.W., Wash., D.C.

19. 10-15 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 15 19 47 at 12:08 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 October 19 47 to 15 October 19 47 and that I last saw him alive on 15 October 19 47

Immediate cause of death	DURATION
Thrombosis, Coronary artery	6 hrs.
Due to Coronary Heart Disease	18 months
Due to Congestive Heart Failure	16 months
Other conditions Arteriosclerosis, general	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Thrombosis, Coronary artery; Arteriosclerosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: W. A. Dinsmore Jr. W. A. DINSMORE, LCDR MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 10-15-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

51 b+ 09201

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda —
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, Institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Gaithersburg, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: No street Number
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME Howard, George Martin

3.(b) Social Security Number 577-12-0924

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Cora Howard
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): APRIL 13, 1887

8. AGE: Years	Months	Days	If less than one day
60 60	6	0	— hrs. — min.

9. Birthplace: Frederick, Maryland (Town, county, and state)
10. Usual occupation: Printers Helper
11. Industry or business

FATHER
12. Name: George Howard
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lovanna Warner
15. Birthplace: Maryland

16. Informant: Miss Dorothy Howard
Address: Gaithersburg, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/16/47 (month) (day) (year)
Cemetery or crematory: Neelsville Presbyterian Church cemetery
Location: Germantown, Maryland

18. Funeral director: Wm Reuben Humphrey
Address: 7557 Wisconsin Ave., Bethesda, Md.

19. 10/16 1947 (Date rec'd by registrar) Wm E Jubar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 13 1947, at 9:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 7 1947 to Oct 13 1947
and that I last saw h. alive on Oct 13 1947.

	DURATION
Immediate cause of death: post operative shock	12 hours -
Due to: supra pubic cystotomy	
Because of:	
Due to: CARCINOMA of prostate	1 yr
Other conditions: Obstruction Uremia	1 yr -

(Include pregnancy within 3 months of death)

Major findings of operation: Carcinoma prostate —
Date of op. Oct 13, 47 —
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Willis V. Mehl — M. D. or other
Address: Rockville Date signed Oct 14, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09202

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH:

County: Montg Co.,

City or town: Gaithersburg Md.,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montg.

City or town: Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles Richard Howes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: May W Howes

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 11 1890

8. AGE: Years	Months	Days	If less than one day
1890 57	5	6	..... hrs. ..... min.

9. Birthplace: Montg Co, Md,
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: John Howes

13. Birthplace: Md.

MOTHER — 14. Maiden name: Helen Gaither.

15. Birthplace: Md,

16. Informant: Lee M. Howes

Address: Washington Grove. Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/19/47 (month) (day) (year)

Cemetery or crematory: Forest Oak Cemetery

Location: Gaithersburg Md,

18. Funeral director: Ernest C. Gartner

Address: Gaithersburg. Md,

19. Oct. 17 19 47 Rhuda L. Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 17 19 47, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 17 19 47 to ..... 19 .....

and that I last saw h..... alive on ..... 19 .....

Immediate cause of death: Coronary occlusion — DURATION: died suddenly

Due to: .....

Due to: .....

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Bouchat M. D. Asst. Med. Exam. M. D. or other

Address: Gaithersburg md Date signed 10-17-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09203

CERTIFICATE OF DEATH

Reg. Dist. No. 212

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Dickerson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Dickerson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sarah Russell Hoyle

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

8.(b) Name of husband or wife James F Hoyle

8.(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Feb 17 - 1875

8. AGE:

Years	Months	Days	If less than one day
72	8	2	...hrs. ...min.

9. Birthplace Germantown, W. Va. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name James T Russell

13. Birthplace Virginia

MOTHER

14. Maiden name Virginia Gardner

15. Birthplace West Virginia

16. Informant James Hoyle

Address Dickerson, Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Oct 21-47 (month) (day) (year)

Cemetery or crematory Montevue

Location Beallsville, Md

18. Funeral director William B. Hilton

Address Barnesville, Md.

19. Oct 20 1947 (Date rec'd by registrar) Mrs. C. C. Hilton By Mrs. W. B. H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19th, 1947, at 9:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17th, 1946, to October 19 1947

and that I last saw her alive on October 18th, 1947

Immediate cause of death	DURATION
Coronary occlusion	12 hours
Due to Primary attack, Nov. 17,	1946
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. H. Conley M. D. or other

Address Frederick, Maryland Date signed 10/20/47

09204

Twin # 2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 hours. 45 min.
Hospital, Institution, or street address where death occurred:
Suburban Hospital Georgetown Rd.
How long in hospital or institution? 33 hours, 45 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8721 Ridge Road
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Infant Huddleson (Twin #2) **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	—

6.(b) Name of husband or wife
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1947

8. AGE: Years | Months | Days: 1 | If less than one day: 9 hrs. 45 min.

9. Birthplace Bethesda (Montgomery Co.) Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Charles Harvey Huddleson
13. Birthplace Washington, D. C.

MOTHER
14. Maiden name Betty June Evelyn Baeck
15. Birthplace La Crosse, Wis.

16. Informant —
Address

17. Removed (Burial, cremation, or removal. Which?) CREMATION Date thereof Oct. 19/47 (month) (day) (year)
Cemetery or crematory Suburban Hospital
Location 8600 OLD Georgetown RD BETHESDA Montgomery Co. Md.

18. Funeral director A.B. Solem, Supt
Address above

19. 10/23 19 47 (Date rec'd by registrar) Wm. E. Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 19 47 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 17 19 47 to Oct 19 19 47
and that I last saw h 19 alive on Oct 19 19 47

Immediate cause of death	DURATION
Atelectasis	2 days
Due to Premature	
Due to —	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE R H Mitchell M D (M. D. or other)
Address Bethesda Md Date signed Oct 19 '47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Twin #1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

09205 316

Reg. Dist. No.

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 hours, 45 min.
Hospital, institution, or street address where death occurred: Suburban Hospital 9600 old Georgetown Road
How long in hospital or institution? 10 hours, 45 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7121 Ridge Road
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Infant (male) #1 Huddleson.

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant

6.(b) Name of husband or wife: /
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): October 17, 1947

8. AGE: Years: / Months: / Days: / If less than one day: 10 hrs. 45 min.

9. Birthplace: Suburban Hospital, Bethesda, Md. (Town, county, and state)

10. Usual occupation: /

11. Industry or business: /

FATHER
12. Name: Charles Harvey Huddleson
13. Birthplace: Washington, D.C.

MOTHER
14. Maiden name: Betty Jane Evelyn Boeck
15. Birthplace: La Crosse, Wisconsin.

16. Informant: ____
Address: ____

17. (Burial, cremation, or removal. Which?) Removal-Cremation Date thereof: October 19 '47 (month) (day) (year)
Cemetery or crematory: /
Location: Suburban Hospital 8600 Old Georgetown Road

18. Funeral director: A. B. Saxon Chapel
Address: Bethesda 14, Md.

19. 10/23 1947 (Date rec'd by registrar) Mrs. E. J. Lees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18 1947 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 17 1947 to Oct 18 1947
and that I last saw him alive on Oct 18 1947

	DURATION
Immediate cause of death: Atelectasis	9 hrs.
Due to: Premature birth	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: R. H. Mitchell M.D.
M. D. of other
Address: 7124 Wisconsin Ave Bethesda Md. Date signed: Oct. 18 '47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93e

09206

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Potomac, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 hrs.
Hospital, institution, or street address where death occurred:
Rest Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Ashton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: HUETTE, GUSTAVE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Bertha Karste deceased
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 29, 1861

8. AGE: Years	Months	Days	If less than one day
86	4	18	hrs. min.

9. Birthplace: Sheboygan, Wisconsin (Town, county, and state)
10. Usual occupation: Manufacturer, Furniture
11. Industry or business

FATHER
12. Name: Theodore Huette
13. Birthplace: Germany

MOTHER
14. Maiden name: Marie ?
15. Birthplace: Germany

16. Informant: Mrs. Norma H. Clas
Address: Ashton, Maryland

17. Shipment (Burial, cremation, or removal. Which?) Date thereof 10/19/47 (month) (day) (year)
Cemetery or crematory: Wildwood Cemetery
Location: Sheboygan, Wisconsin

18. Funeral director: Wm Reuben Humphreys
Address: Bethesda, Maryland

19. 10/17 1947 (Date rec'd by registrar) Mr E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 Oct 1947 at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1946 to 17 Oct 1947 and that I last saw h. alive on 17 Oct 1947

Immediate cause of death	OURATION
Acute Congestive Heart Failure	4 days
Due to: Coronary Sclerosis	2 yrs
Due to: Arteriosclerosis	20 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W E Murphy M.D. M.D. or other
Address: Rockville Md Date signed 17 Oct 47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09207

186a

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:

County: Monty

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

800 Pershing Dr.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Monty

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 800 Pershing Dr.

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: David J. Hughes

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widowed

6.(b) Name of husband or wife: Florence

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 20th. 1863

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
84	6	21		

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Guard

11. Industry or business: Corcoran Art Gallery

FATHER — 12. Name: Frank HUghes

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Mr. Fred J. Hugges, Sr.

Address: 800 Pershing Drive.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/15/1947 (month) (day) (year)

Cemetery or crematory: Andrews Chapel

Location: Fairfax Co. Virginia.

18. Funeral director: Warner Thompson

Address: Silver Spring, Md.

19. Oct 13 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 11 1947, at 12:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
	during
Cerebral hemorrhage	instantly
Due to Fell down steps of	
his home	
Due to Accidental	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 10-11-47

Where did injury occur? Silver Spring (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?): home

Means of injury: Fall Injured at work? no

23. SIGNATURE: Frank J. Broccard M.D. Dep. Med. Exam. M. D. or other

Address: Gaithersburg Md. Date signed: 10-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

09208

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda, Md
(If outside city of town limits, write RURAL and give nearest town)
How long in above place of death? Since Aug 19, 1947
Hospital, Institution, or street address where death occurred: Suburban Hospital - 8600 Old Georgetown Rd, Bethesda, Md
How long in hospital or institution? Since Aug 19, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8003 Eastern ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME J. Bacon Hyatt

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, Married, Widowed, or Divorced
Male	White	Married.

6.(b) Name of husband or wife Hilah Hyatt
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 23, 1884

8. AGE:

Years	Months	Days	If less than one day
63	6	12	..... hrs. ..... min.

9. Birthplace Delaware (Town, county, and state)
10. Usual occupation Auditor (Retired)
11. Industry or business

MOTHER FATHER
12. Name George Hyatt
13. Birthplace Delaware
14. Maiden name Lida Barton
15. Birthplace Delaware

16. Informant Mrs Hilah Hyatt
Address 8003 Eastern ave. Silver Spring Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 18, 1947 (month) (day) (year)
Cemetery or crematory Green Hill
Location Waynesboro, Pa.

18. Funeral director Walter G Grove
Address 27 S Church St. Waynesboro Pa

19. 10/6/47 (Date rec'd by registrar) Mr E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15 1947, at 3:28 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1943, to Oct. 15 1947
and that I last saw h.. alive on Oct. 15 1947

	DURATION
Immediate cause of death Chronic Myocarditis	
Due to Coronary Arteriosclerosis	
Due to	
Other conditions Generalized arterio-sclerosis. Cirrhosis of liver. Diabetes Mellitus. (Include pregnancy, within 3 months of death)	

Major findings of operations Cholelithiasis Date of op. Jan 1947
Autopsy results Confirmation of above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J Marion Bamstead M.D.
M. D. or other
Address 9601 Dutton Place Silver Spring, Md Date signed 10/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

Jobes.
512 Maple Ridge

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09209

CERTIFICATE OF DEATH

Reg. Diat. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 years.

Hospital, institution, or street address where death occurred:

228 Spruce Avenue.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 228 Spruce Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: none.

3. (a) FULL NAME GUSTAV HERMAN JAKOBSSON

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Man	White	Married

6.(b) Name of husband or wife: Greda Jakobsson

6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): Feb. 16, 1860

8. AGE:

Years	Months	Days	If less than one day
87	8	7	...hrs. ...min.

9. Birthplace: Sweden (Town, county, and state)

10. Usual occupation: Patent Attorney

11. Industry or business: Some

FATHER

12. Name: Unknown

13. Birthplace: Unknown

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Mrs. Hallie M. Gates

Address: 7205 8th St. NW. Wash D.C.

17. (Burial, cremation, or removal. Which?) Cremation. Date thereof (month) Oct. (day) 25, (year) 1947

Cemetery or crematory: Cedar Hill Crematory

Location: Suitland Road at Md. State Line, Pr. Geo. County Md.

18. Funeral director: J. Arthur Waters

Address: 754 Carroll St NW Wash DC

19. (Date rec'd by registrar) Oct. 24 19 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 23 October 1947, at 7 30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 7 Oct. 1947 to 23 Oct. 1947 and that I last saw him alive on 22 Oct. 1947

Immediate cause of death	DURATION
Coronary Artery Disease.	
Due to: Senile Arteriosclerosis.	
Due to:	
Other conditions: None.	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? (City or town) (County) (State) —

Injured at home, farm, industry, public place (where?) —

Means of injury: Injured at work?

23. SIGNATURE: G B Lucas M.D. M. D. or other

Address: 112 Willow Ave. Takoma Park, Md. Date signed: 23 Oct. 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09210

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or townlimits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4706 Highland Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs - Elizabeth James

3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: widow
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): March 15, 1889
8. AGE: Years: 58 Months: 7 Days: 6 If less than one day: hrs. min.
9. Birthplace: Russia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Abraham Schurman
13. Birthplace: Russia
MOTHER 14. Maiden name: Esther Breitman
15. Birthplace: Russia
16. Informant: Milton James (son)
Address: Sande
17. Shipment (Burial, cremation, or removal. Which?) Date thereof 10/22/47 (month) (day) (year)
Cemetery or crematory: Chicago, Illinois
Location: Chicago, Illinois
18. Funeral director: Wm Reuben Dunphey
Address: Bethesda, Maryland
19. 10/22 1947 (Date rec'd by registrar) Wm E Forbes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct - 21, 1947 at 10 20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1947 to Oct 21 1947 and that I last saw her alive on 10 - 21 1947
Immediate cause of death: Carcinoma of lung — DURATION: 1 yr
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul A Canby MD
M. D. or other
Address: Bethesda Date signed 10-22-47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1246

09211

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 637 Q St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: WWI ✓

3.(a) FULL NAME: JONES, Horace Clark

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col-US	married

6.(b) Name of husband or wife: Lena Jones
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 2, 1886

8. AGE: Years	Months	Days	If less than one day
61	0	18	hrs. min.

9. Birthplace: N.C. (Town, county, and state)
10. Usual occupation: unemployeed
11. Industry or business

FATHER
12. Name: JONES, Netwon dec
13. Birthplace: N.C.

MOTHER
14. Maiden name: NAPTHA, Susan dec.
15. Birthplace: N.C.

16. Informant: wife: Mrs. Lena Jones,
Address: 637 Q St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 10-23-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: W. ERNEST JARVIS
Address: 1432 U St., N. W., Wash. D.C.

19. 10-20 19 47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 20 19 47 at 12 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 14 19 47 to Oct. 20 19 47 and that I last saw him alive on 20 October 19 47

Immediate cause of death	DURATION
Pneumonia Primary stated 7 days	
Due to	
Due to Cirrohsis liver	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: confirmed above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: injured at work?

23. SIGNATURE: R. H. C. SMITH, Cdr. MC USN M. D. or Other
Address: USNH Bethesda, Md. Date signed: 10-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 09212

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: TAKOMA PARK, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:
WASHINGTON SAN + HOSP

How long in hospital or institution? 13 days 21 hrs 10 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: MONTGOMERY

City or town: BETHESDA
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4402 Bywood Lane.
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: JOHN G. KELLAR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: MRS. EDNA A. KELLAR

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): MARCH 11, 1871

8. AGE: Years	Months	Days	If less than one day
76	7	10	...hrs. ...min.

9. Birthplace: PEORIA, ILLINOIS
(Town, county, and state)

10. Usual occupation: HYDROGRAPHIC WORKER (CIVILIAN)

11. Industry or business: NAVY

FATHER
12. Name: JAMES G. KELLAR
13. Birthplace: PEORIA, ILLINOIS

MOTHER
14. Maiden name: HARRIETTE CALLISCA HUMASON
15. Birthplace: PEORIA, ILLINOIS

16. Informant: MRS. EDNA KELLAR
Address: 4402 Bywood Lane

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/23/47 (month) (day) (year)

Cemetery or crematory: Rock Creek Cemetery

Location: Washington, D. C.

18. Funeral director: Pumphrey's Wm. Reuben
Address: Wisconsin Ave, Bethesda Md.

19. Oct 22 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 21 1947 at 1205 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AUGUST 12 1947 to OCTOBER 21 1947 and that I last saw h.i.M. alive on OCTOBER 21 1947

	DURATION
Immediate cause of death: Arteriosclerotic Heart Disease	3 YEARS
Due to: Coronary Artery Sclerosis	3 YEARS
Due to: Arteriosclerosis	10 YEARS
Other conditions: Asystemia	2 WEEKS

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Mssns of injury Injured at work?

23. SIGNATURE: Robert G. Cuggle, M.D.
M. D. or other

Address: 106 East Kay ave. Bethesda, Montgomery Co. Md. Date signed Oct. 22, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

Reg. Dist. No. 09213 2/14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:

County: Monty

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs

Hospital, institution, or street address where death occurred:
9718 Colesville Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Monty

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9718 Colesville Rd
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3. (a) FULL NAME: John James Knight

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Ellen A. Knight

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): June 12 1878

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
69	4	18		

9. Birthplace: Ireland (Town, county, and state)

10. Usual occupation: Retired Motorman

11. Industry or business: Police Force

FATHER
12. Name: John C. Knight
13. Birthplace: Ireland

MOTHER
14. Maiden name: Bridget Kelley
15. Birthplace: Ireland

16. Informant: Clifton R. Willingham
Address: 212 Francis Dr Silver Spring Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-30-47 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Suitland Md. Prince George Co.

18. Funeral director: The S. H. Hines Co.

Address: 2901 14th St. N.W.

19. Oct 27 1947 (Date rec'd by registrar) Josephine A. Shaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 27 1947, at 3:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam. 19..., to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Coronary occlusion	Instantaneous
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Brochard M.D. Dep. Med. Exam. M. D. or other

Address: Gaithersburg Md. Date signed: 10-27-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

09214

CERTIFICATE OF DEATH

Reg. Dist. No. 16

1. PLACE OF DEATH:

County: Montgomery

City or town: Rural Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since birth

Hospital, institution, or street address where death occurred: Suburban Hospital, Geo. Rd

How long in hospital or institution? birth

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Homer Lane Route #4

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: Infant Boy Rocher

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Single

6.(b) Name of husband or wife:

B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 21-1947

8. AGE: Years | Months | Days | If less than one day: 3 hrs. 30 min.

Viable - Heart beat

9. Birthplace: Bethesda, Montgomery, Maryland. (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER

12. Name: Franklin Charles Rocher

13. Birthplace: Meyersdale, Penn.

MOTHER

14. Maiden name: Ruth Elna Young

15. Birthplace: Elkrun, Ohio.

16. Informant: Ruth Elna Young Rocher

Address: Rockville Maryland

17. Shipment (Burial, cremation, or removal. Which?) Date thereof 10/22/47 (month) (day) (year)

Cemetery or crematory: Uniontown Cemetery.

Location: Uniontown, Ohio

18. Funeral director: Wm. Rawlens Pumphrey

Address: Bethesda, Maryland

19. 10/22/47 (Date rec'd by registrar) Wm E Foley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 21 1947 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 21 1947 to Oct 21 1947

and that I last saw h. alive on Oct 21 1947

Immediate cause of death	DURATION
Premature	—
Due to (5 months - 1836 g)	
Due to —	
Other conditions none	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. A. Smithson, M.D. M. D. or other

Address: Rockville, Md. Date signed 10/21/47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1570

09215

CERTIFICATE OF DEATH

Reg. Diat. No. 223

1. PLACE OF DEATH:

County Montgomery Co.

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? two days

Hospital, institution, or street address where death occurred

Wash. San. & Hosp.

How long in hospital or institution? Two days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 403 Beech Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles Edward Land

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/26/47

8. AGE: Years | Months | Days 2 | If less than one day hrs. min.

9. Birthplace Takoma Park (Town, county, and state)

10. Usual occupation None.

11. Industry or business

FATHER 12. Name Edwin Wade Land.

13. Birthplace New Bern N.C.

MOTHER 14. Maiden name Catherine Tuna Holeman

15. Birthplace Wash. D.C.

16. Informant E. W. Land

Address San Records.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct - 29 - 1947 (month) (day) (year)

Cemetery or crematory Glenwood Cemetery

Location Takoma D.C.

18. Funeral director Fletcher Wallace

Address 754 Carroll Ave. Takoma Park

19. Oct 29 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1947 at 10 35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 26 1947 to Oct 28 1947 and that I last saw him alive on Oct 28 1947

	DURATION
Immediate cause of death: Atelectasis of Lung.	2 days
Due to: Congenital Heart	
Due to: Imperfect Fetal Development	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Howard I Simons M.D.

M. D. or Coroner

Address Date signed 10/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

09216

Reg. Diat. No. 223

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park 12 Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Month

Hospital, Institution, or street address where death occurred:
Washington Sanitarium & Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Pennsylvania County

City or town Prospect Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 122 Penn. Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Miss Betty Wawton

3.(b) Social Security Number

4. Sex FEMALE

5. Color or race Female White

6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 11, 1927

8. AGE: Years 19 | Months 11 | Days 8 | If less than one day ..... hrs. ..... min.

9. Birthplace Philadelphia Penna.
(Town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER
12. Name Edward S. Wawton
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Sophie Sparling
15. Birthplace Canada

16. Informant Mrs. Stevens

Address 691 Carroll Ave, Takoma Park Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 11, 1947 (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director Arthur Fellers

Address 254 Carroll St. Takoma Park D.C.

19. Oct 9 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8/1947, at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 6 1947 to Oct 7 1947 and that I last saw h[illegible] alive on Oct 6 1947

	DURATION
Immediate cause of death: Mitral Central Edema & Congestion	
Due to:	
Due to:	
Other conditions: Cardiovascular failure	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results None to be obtained Later

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Howard [illegible] M. D.

Address 691 Carroll Ave Takoma Park Md M. D. or coroner

Date signed 10/8/47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

09217

CERTIFICATE OF DEATH

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct and is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? one day
Hospital, Institution, or street address where death occurred:
805 Maple Ave (A rest home)
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7016 Eastern Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: (Mrs.) Nancy Read Ludwig

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Edwin T. Ludwig
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 14 1871

8. AGE: Years	Months	Days	If less than one day
76			hrs. min.

9. Birthplace: Louisville Ky.
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business

FATHER
12. Name: William John Fuller
13. Birthplace: Ky.

MOTHER
14. Maiden name: Read
15. Birthplace: Ky.

16. Informant: Mr Walter F. Ludwig
Address: 4520 - 32nd, Road N. Arlington, Va.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Oct 30 1947 (month) (day) (year)
~~Cemetery~~ or crematory: J. William Lee's Sons Co.
Location: Washington D.C.

18. Funeral director: J. William Lee's Sons Co.
Address: 300 - 4th, St. N.E. Washington, D.C.

19. Oct 29 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 27, 1947, at 8:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 20, 1947, to Oct 27, 1947, and that I last saw h[illegible] alive on Oct. 27, 1947.

	DURATION
Immediate cause of death: Cerebral hemorrhage	1 day
Due to: Arterio-sclerosis	10 yrs
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. B. Kelly M.D. M. D. or other
Address: 6911 5th st. N.W. Washington D.C.
Date signed: 10/27/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

09218

Reg. Dist. No. 916

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: WESTMORELAND HILLS

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs.

Hospital, institution, or street address where death occurred:

8 WORTHINGTON DRIVE

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MD. County: MONTGOMERY

City or town: WESTMORELAND HILLS

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8 WORTHINGTON DRIVE

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: HENRI JOSEPH LUTZ

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	White	MARRIED

6.(b) Name of husband or wife: ELISA TILLE LUTZ

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): OCT. 19, 1881

8. AGE: Years	Months	Days	If less than one day
66	0	5	— hrs. — min.

9. Birthplace: PARIS FRANCE (Town, county, and state)

10. Usual occupation: CHEF

11. Industry or business: —

MOTHER FATHER

12. Name: HENRI LUTZ

13. Birthplace: FRANCE

MOTHER

14. Maiden name: ANNA MARIE BENTZINGER

15. Birthplace: FRANCE

16. Informant: RENE LUTZ

Address: 5620 MADISON, BETHESDA MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 10-27-47 (month) (day) (year)

Cemetery or crematory: FORT LINCOLN CEM.

Location: WASH.-BALT. BLVD. DISTRICT LINE, MARYLAND

18. Funeral director: Joseph Gawler's Sons

Address: 1756 Pa. Ave. N.W.

19. Oct. 26, 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 24 1947, at 7:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1947, to Oct. 24 1947, and that I last saw him alive on Oct. 23rd 1947.

	DURATION
Immediate cause of death: Acute Heart Failure	2 hours.
Due to: Cerebral Arterio-Sclerosis	3 years.
Due to:	
Other conditions: Inanition & Dehydration.	1 month

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury Injured at work?

23. SIGNATURE: S. Logan Mercer, M.D. M. D. or other

Address: 1316 N.H. Ave. Wash. D.C. Date signed 10-25-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

2108

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

09219

Reg. Diat. No. 2/8

1. PLACE OF DEATH:

County: Montg Co

City or town: Gaithersburg Md,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Va. County:

City or town: Manassas

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Grace Nicol Maphis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Dr B F, Maphis

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 10th 1870

8. AGE:	Years	Months	Days	If less than one day
1870	76	11	22	hrs. min.

9. Birthplace: Brentsville Va,

(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business

FATHER

12. Name: Aylett Nicol

13. Birthplace: Va,

MOTHER

14. Maiden name: Louise Sprinkle

15. Birthplace: Va.

16. Informant: Rev H M Wilson

Address: Gaithersburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/4/47 (month) (day) (year)

Cemetery or crematory: Nicol Burial Ground

Location: Brentsville Va,

18. Funeral director: Ernest C Gartner

Address: Gaithersburg, Md,

19. Oct. 4 (Date rec'd by registrar) 19 47 Rhuda L Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 2nd 19 47 at 2 10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug - 14 - 1947 to Oct - 2 - 1947 and that I last saw h[illegible] alive on Oct - 1 - 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage -	37 days
Due to: High arterial tension - 10 or more years	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE: William C. Miller, M.D. M. D. or other

Address: Gaithersburg, Md. Date signed 10/3/47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09220

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:
County Montgomery
City or town near Brookville Md Rural
(If outside city or town limits, write RURAL and give nearest town) R
How long in above place of death? Ten Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Near Brookville Rural R F D
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Barbra Mathis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Married

6.(b) Name of husband or wife John F Mathis
6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) 17 July - 1881

8. AGE:

Years	Months	Days	If less than one day
66	2	19	hrs. min.

9. Birthplace Snowhill Penn
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Farm Hobbs.
FATHER 12. Name John Hobbs
13. Birthplace Penn
MOTHER 14. Maiden name Lucinda Hobbs
15. Birthplace Penn
16. Informant John F. Mathis
Address Brookville md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 9 - 1947 (month) (day) (year)
Cemetery or crematory Baptist Church
Location Howard Co Md
18. Funeral director Roy W Barber
Address Laytonsville md
19. 10/9/47 19 (Date rec'd by registrar) Louis O Hall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6 1947, at 3 25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/1/ 1947, to 10/6/ 1947
and that I last saw h alive on 10/2/ 1947

Immediate cause of death	DURATION
Cardiac Dilitation	2 days
Due to Chronic Myocarditis	6 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J M D
M. D. or other
Address Laytonsville Md Date signed 10/8/47

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.


RECEIVED
OCT 13 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09221

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4801 Connecticut Avenue, N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME: MC CUBBIN, John Carr

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 20, 1882

8. AGE: Years	Months	Days	If less than one day
64	10	18	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Retired Government

11. Industry or business

FATHER
12. Name: MC CUBBIN, Charles John dec
13. Birthplace: Canada

MOTHER
14. Maiden name: CARR, Mary Eva dec
15. Birthplace: Md.

16. Informant: daughter: Mrs. W. E. Carey
Address: 4801 Connecticut Avenue, N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 10-11-47 (month) (day) (year)

Cemetery or crematory: Rock Creek

Location: Washington, D. C.

18. Funeral director: Chevy Chase Funeral Home

Address: 5103 Wisconsin Avenue, Chevy Chase, D.C.

19. 10-9 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 October 19 47, at 1:48 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 Sept. 19 47 to 8 Oct. 19 47 and that I last saw h im alive on 8 Oct. 19 47

Immediate cause of death	DURATION
Myocardial Infarction	4 mo.
Pulmonary Embolism	10 min.
Due to Coronary Thrombosis	
Due to	
Other conditions Pulmonary Embolism (Include pregnancy within 3 months of death)	10 min±

Major findings of operations: NONE Date of op.

Autopsy results: Confirmed Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. L. C. Stevens Jr. H. L. C. STEVENS, Jr. Lt. JG MC USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed 10-9-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

09222

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
10,000 Georgia Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8708 Geren Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: LOTTIE BLESSING JONES MELTON

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Benjamin Mark
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 31st. 1863

8. AGE: Years	Months	Days	If less than one day
83	9	2	hrs. min.

9. Birthplace: Bosque Co. Texas (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Starr S. Jones
13. Birthplace: Mass.

MOTHER
14. Maiden name: Nancy E. Hollenbank
15. Birthplace: Texas

16. Informant: Mr. Benjamin Starr Melton
Address: 8708 Geren Rd. Silver Spring.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-4-1947 (month) (day) (year)
Cemetery or crematory: ~~xxxxx~~ Grace Church
Location: Woodside, Montg. Co., Md.

18. Funeral director: Warner E Pumphrey
Address: Silver Spring, Md.

19. Oct 2 1947 (Date rec'd by registrar) Joseph M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 October 1947, at 3:30 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 28 June 1947, to 2 Oct. 1947 and that I last saw h[illegible] alive on 23 Sept. 1947

Immediate cause of death	DURATION
Cardiac Failure	One week
Due to: Cerebral Hemorrhage left Hemiplegia	2 months 2 years
Due to: Arteriosclerosis generalized and Hypertension	
Other conditions: Hemiplegia	2 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None performed.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John B. Bell M.D. M. D. or other
Address: 936 Hungerford Rd Bethesda Md. Date signed 2 Oct 47.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09223

836

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 4 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2900 Q Street, N. W.,
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MITCHELL, Anne Clark

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-IS	married

6.(b) Name of husband or wife: Robert Clark Mitchell

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 19, 1907

8. AGE: Years	Months	Days	If less than one day
40	1	5	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER
12. Name: CARRUTHERS, Marie M.
13. Birthplace: Ohio

MOTHER
14. Maiden name: CLARK, George E. dec.
15. Birthplace: Wash., D.C.

16. Informant: husband: Chief Robert C. Mitchell, USN
Address: Receiving Station, Phila., Penn.

17. burial (Burial, cremation, or removal. Which?) Date thereof 10-27-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: S. H. HINES

Address: 2901 14th St., N. W., Wash., D.C.

19. 10-24 (Date rec'd by registrar) 19 47 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 October 19 47 at 3:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 Sept. 19 47 to 24 Oct. 19 47 and that I last saw h... im alive on 24 October 19 47

Immediate cause of death	DURATION
Massive Infarction of the left Cerebral Hemisphere	24-48hrs
Due to	
Due to	
Other conditions: Ulcerative Colitis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: Ulcerative Colitis, Cerebral Infarction

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. C. Matowitz, Lt. (jg) MC USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 10-24-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

09224

CERTIFICATE OF DEATH

Reg. Diat. No. 298

1. PLACE OF DEATH:

County: Montg Co,

City or town: Gaithersburg Md,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3Yrs 9 Mo

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Oradie May Moxley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Robert S Moxley

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 14th 1880

8. AGE: Years	Months	Days	If less than one day
1880 67	1	17	hrs. min.

9. Birthplace: Monrovia Md,
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: ff

FATHER
12. Name: William J EASTON
13. Birthplace: Md

MOTHER
14. Maiden name: Mary F Duvall
15. Birthplace: Md

16. Informant: Rev H M Wilson,
Address: Gaithersburg Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/3/47 (month) (day) (year)

Cemetery or crematory: Montgomery Chapel Cemetery
Location: Damascus, Md,

18. Funeral director: Ernest C Gartner
Address: Gaithersburg Md,

19. Nov 2 19 47 Amos B Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 31st 19 47 at 6 Pm M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April - 22 - 19 47 to Oct - 31 - 19 47 and that I last saw h alive on Oct - 28 - 19 47

Immediate cause of death	DURATION
Acute heart failure	5-10 minutes
Due to: Cardio - nephritis	1 year
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William C. Hilleary M.D. M. D. or other

Address: Gaithersburg, Md Date signed 11/1/47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

107

Reg. Dist. No. 7-14 09225

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Hospital, Institution~~ or street address where death occurred:
820 Woodside Parkway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 820 Woodside Parkway
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: MARY ELIZABETH MURPHY

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: James S.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 18th. ~~1865~~ 1866

8. AGE: Years: ~~82~~ 81 | Months: 1 | Days: 23 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Philadelphia, Pa.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: Jerimiah Toomey
13. Birthplace: Ireland

MOTHER
14. Maiden name: Ann - - -
15. Birthplace: Ireland

16. Informant: Joseph D. Murphy
Address: 820 Woodside Parkway

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/14/47 (month) (day) (year)

Cemetery or crematory: Mt. Olivet

Location: Washington, D.C.

18. Funeral director: Warren Cassingbery

Address: Silver Spring, Md.

19. Oct 13 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 11 1947, at 1:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1947, to Oct 11 1947

and that I last saw h.e.r alive on Oct 10 1947

Immediate cause of death	DURATION
General debility and senility	1
Due to: Bronchopneumonia	1 wk.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: —

Date of op.:

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank G. Zack M.D. M.D. or other

Address: 8248 Fa Ave Silver Spring Md. Date signed: 10-11-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09226

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 minutes
Hospital, institution, or street address where death occurred: USNH Bethesda, Md.
How long in hospital or institution? 30 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A.A.
City or town: Annapolis, Homoja Village
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 15 Kingwood
(If rural, give LOCATION)
2.(a) If veteran, name war: WW II

3.(a) FULL NAME: NYCKLEMOE, Palmer Donovan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	married

6.(b) Name of husband or wife: Frances Nycklemoe
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 26 May 1921

8. AGE: Years	Months	Days	If less than one day
26	4	29	..... hrs. ..... min.

9. Birthplace: Spokane, Washington (Town, county, and state)
10. Usual occupation: U. S. Navy
11. Industry or business: U. S. Navy

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Wife: Mrs. Frances Nycklemoe
Address: 15 Kingwood, Homoja Village, Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 31 47 (month) (day) (year)
Cemetery or crematory: National Cemetery
Location: Minneapolis, Minnesota

18. Funeral director: W. W. Chambers Co. E.J.
Address: 1400 Chapin Street, NW, Washington, D. C.

19. 10-25 19 47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 25 1947 at 5:30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Def. Med. Exam 19 ..... to ..... 19 ..... and that I (last saw h.....) alive on Oct 25 1947

Immediate cause of death	DURATION
Fracture of skull	1 hr.
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of Oct 25 '47
Where did injury occur? Rockville (City or town) Monty (County) Md (State)
Injured at home, farm, industry, public place (where?) —
Means of injury: aeroplane, crash Injured at work? yes

23. SIGNATURE: Frank J. Broschart M.D. Def. Med. Exam M. D. or other
Address: Gaithersburg, Md. Date signed: 10-25-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

09227

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Sudden death

Hospital, Institution, or street address where death occurred:
Bethesda Police Station

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6207 Wagner Lane, Bethesda, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war World War II

3.(a) FULL NAME John Joseph Peace (Peace)

3.(b) Social Security Number 579-10-0920

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1914

8. AGE: Years	Months	Days	If less than one day
33yrs	3	13	hrs. min.

9. Birthplace Pfalzelon Dermoselle, Germany
(Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business

FATHER
12. Name Joseph Pies
13. Birthplace Germany

MOTHER
14. Maiden name Albertina Steinbach
15. Birthplace Germany

16. Informant Mr. Ralph E. Pies
Address 6207 Wagner Lane, Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/22/47 (month) (day) (year)

Cemetery or crematory Arlington National Cem.

Location Arlington, Virginia

18. Funeral director Wm Reuben Humphrey

Address 7557 Wis. Ave. Bethesda, Maryland

19. 10/21 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 19 47, at 3:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 19 47 to Oct 20 19 47 and that I last saw h alive on 19

Immediate cause of death	DURATION
Fracture of skull with extra-dural hemorrhage	6½ hrs.
Due to Fall — accidental	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accidental Date of 10-20-47

Where did injury occur? Bethesda (City or town) Montg (County) Md (State)

Injured at home, farm, industry, public place (where?) street

Means of injury Fall Injured at work? No

23. SIGNATURE Frank J. Bronstad M.D.
M. D. or other

Address Gaithersburg Md Date signed 10-20-47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160a 09228 217

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: The Montgomery County General Hospital Inc.

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Howard

City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)

Street No. Crain's Trailer Park
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph Henry Peery

3.(b) Social Security Number —

4. Sex Male

5. Color or race White

6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) October 28, 1947

8. AGE: Years — Months — Days 2 — If less than one day ... hrs. ... min.

9. Birthplace Olney, Montgomery Co., Maryland
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name Emmett Junior Peery

13. Birthplace Bluefield, West Virginia

MOTHER 14. Maiden name Della Hassie Hensly

15. Birthplace Lafayette, Tenn

16. Informant Hospital records

Address

17. Burial (Burial, cremation, or removal, Which?) Date thereof 10-31-47 (month) (day) (year)

Cemetery or crematory St Johns

Location Ellicott City Md

18. Funeral director F.C. Higinbotham

Address Ellicott City Md

19. Oct. 31, 1947 (Date rec'd by registrar) John B. Loughman Registrar
Gertrude B. Lawler Dep. R.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 1947, at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 28 1947, to October 30 1947

and that I last saw h... alive on October 30 1947

	DURATION
Immediate cause of death Cerebral hemorrhage	2 days
Due to	
Due to	
Other conditions Congenital hairlip and cleft palate (Include pregnancy within 3 months of death)	2 days

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE [illegible], M.D.
M. D. or other

Address Ellicott City Md Date signed 10/30/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09229

Reg. Diat. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital Bethesda, Md.

How long in hospital or Institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2423 T St., S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: Sp.Am.War

3.(a) FULL NAME: PENNELLA, Martin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mary Rose Pennella 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 19, 1871

8. AGE: Years	Months	Days	If less than one day
76	7	13	hrs. min.

9. Birthplace: Italy
(Town, county, and state)

10. Usual occupation: Retired War Dept.

11. Industry or business: Government

FATHER
12. Name: PENNELLA, A.M. DD
13. Birthplace: Italy

MOTHER
14. Maiden name: ROTUNDO, Mary Rose DD
15. Birthplace: Italy

16. Informant: wife: Mrs. Mary R. Pennella
Address: 2423 T St., S.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 10-6-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Timothy Hanlon W.A.R.

Address: 641 H St., N.E., Wash., D.C.

19. 10-3 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 October 19 47 at 2:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Oct. 19 47 to 2 October 19 47 and that I last saw him alive on 2 October 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 da.
Due to: Arterial Hypertension	10 yrs.
Due to:	
Other conditions: Hypostatic Pneumonia (Include pregnancy within 3 months of death)	2 da

Major findings of operations: Date of op.

Autopsy results: same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. D. NIES, Cdr. MC USN

Address: USNH Bethesda, Md. M. D. or other Date signed: 10-3-47


RECEIVED
OCT 13 1947

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 b

Registered No. 216

03234

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 214- E. Underwood St. Chevy Chase, Md.
(c) Hospital or institution: None
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) None

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Montgomery
(c) City or town Chevy Chase
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 E. Underwood St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BERNICE C. PERKINS

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: unknown

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Charles G. Perkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 14, 1906

8. AGE: Years 40 | Months 10 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace: Birmingham, Alabama (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: None

FATHER
12. Name: Newell Ellard
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Unknown

16 (a) Informant: Charles G. Perkins
(b) Address: Chevy Chase, Maryland

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Oct 29/47 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill Cemetery
Location: Washington, D.C.

18 (a) Funeral director: Wm. Reuben Pumphrey
(b) Address: Bethesda, Maryland

19 (a) 10/30 (Date rec'd by registrar) (b) M E Jules, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 27, 1947, at 3.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Biliary Cirrhosis 11/25/47
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Rynex M.D.
Medical Examiner.
Date signed 10-28-47

VS 151

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

09231

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery County

City or town: 5408-Harwood Rd., Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: ------

How long in hospital or institution? ------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5408-HARWOOD ROAD, BETHESDA, MARYLAND
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: MRS. CLARA SMITH POST

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	WHITE	WIDOWED

6.(b) Name of husband or wife: HARRY K. POST

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): APRIL 27th, 1864

8. AGE:

Years	Months	Days	If less than one day
83			..... hrs. ..... min.

9. Birthplace: PITTSBURGH, PENNSYLVANIA
(Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business

FATHER
12. Name: John Smith
13. Birthplace: Pittsburgh, Pennsylvania

MOTHER
14. Maiden name: Mary Reynolds
15. Birthplace: Pittsburgh, Pennsylvania

16. Informant: Miss Dorothy Post
Address: 5408 HARWOOD ROAD, BETHESDA, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof OCT. 29th, 1947 (month) (day) (year)

Cemetery or crematory

Location: WASHINGTON, PENNSYLVANIA

18. Funeral director: Martin W. Kyne Co.
Address: 1300 N. STREET, N.W. - WASHINGTON, D.C.

19. 10/29 1947 (Date rec'd by registrar) Wm E Jules Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 29th 1947, at 8:30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1944, to Oct 29 1947 and that I last saw h[illegible] alive on Oct 29/47 1947

	DURATION
Immediate cause of death: Coronary occlusion	2 hrs.
Due to: Pernicious Anemia	18 yrs.
Due to:	
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

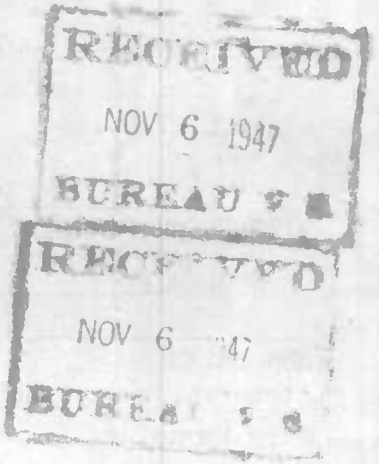
23. SIGNATURE: Geo. Tulloss M. D. or other

Address: 3781 Alton St N.W. Date signed: 10/29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

09232

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The color of this page is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING.

VS A15 9-45-1

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County: Page

City or town: Luray
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3. (a) FULL NAME: PRESGRAVE, Roxie Cleveland

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Lucey Presgrave

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 23 February 1893

8. AGE: Years	Months	Days	If less than one day
54	7	14	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Painter

11. Industry or business: Civil Service

FATHER 12. Name: Samuel Presgrave

FATHER 13. Birthplace: Virginia, deceased

MOTHER 14. Maiden name: Julia Richards

MOTHER 15. Birthplace: Virginia, deceased

16. Informant: Wife: Mrs. Lucey Presgrave

Address: Luray, Virginia

17. Burial (Burial, cremation, or removal. Which?) Date thereof ..... (month) (day) (year)

Cemetery or crematory: Evergreen Cemetery

Location: Luray, Virginia

18. Funeral director: I. C. Bradley Funeral Home

Address: Luray, Virginia

19. 10-8- 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 October 19 47 at 5:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-16- 19 47 to 10-7- 19 47 and that I last saw him alive on 10-7- 19 47

	DURATION
Immediate cause of death: Thrombosis of Coronary Artery	12 hrs
Due to: Coronary Heart Disease, Arteriosclerotic	5 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op. .....

Autopsy results: Permission not granted

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work

23. SIGNATURE: D. E. Billman 11/10/47 D.E.BILLMAN, LTJG MC USNR
M. D. or other

Address: USNH, Bethesda, Md. Date signed: 10-8-47


RECEIVED
OCT 13 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09233

CERTIFICATE OF DEATH

Reg. Diat. No. 212

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yrs.
Hospital, institution, or street address where death occurred:
709 Grandin Avenue
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 709 Grandin Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: GEORGE RHODES RICE Jr.

3.(b) Social Security Number: 213-12-8452

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth S. B. Rice
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): November 19, 1883

8. AGE:	Years	Months	Days	If less than one day
	63	10	17	..... hrs. ..... min.

9. Birthplace: Montgomery County, Maryland
(Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business

FATHER
12. Name: George R. Rice Sr.
13. Birthplace: Indiana

MOTHER
14. Maiden name: Jane Rhodes
15. Birthplace: Virginia

16. Informant: Mrs. Elizabeth S.B. Rice
Address: Rockville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 8, 1947 (month) (day) (year)
Cemetery or crematory: Darnestown Church Cemetery
Location: Darnestown, Maryland

18. Funeral director: Wm. Reardon Pumphrey
Address: Rockville, Maryland

19. Oct 7 1947 (Date rec'd by registrar) E P Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 6 1947, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6 1947, to October 6 1947
and that I last saw him alive on Oct. 6 1947

Immediate cause of death	DURATION
Coronary occlusion	Unk
Due to arterio sclerosis	suddenly
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: G. D. Hartley M.D. M. D. or other
Address: Rockville, Md. Date signed Oct. 7, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

938

09234

Reg. Diat. No. 346

1. PLACE OF DEATH:

County MONTGOMERY

City or town BETHESDA

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital 8600 Old Georgetown Rd. Bethesda 15, Md.

How long in hospital or institution? 6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY

City or town BETHESDA

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4509 HARLING Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME GERTRUDE HOGE RITTER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	White	Widowed

6.(b) Name of husband ~~or wife~~ ALFRED H. RITTER

DECEASED 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 28, 1883

8. AGE: Years	Months	Days	If less than one day
64	3	12	..... hrs. ..... min.

9. Birthplace WASHINGTON, D.C.

(Town, county, and state)

10. Usual occupation HOMEMAKER

11. Industry or business

FATHER 12. Name JOHN T. HOGE

13. Birthplace Ohio

MOTHER 14. Maiden name MARGARET FARRINGTON

15. Birthplace Ohio

16. Informant SISTER MRS. Mildred Wisda

Address 4509 HARLING Road, BETHESDA, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/13/47 (month) (day) (year)

Cemetery or crematory Rock Creek Cemetery

Location Washington, D. C.

18. Funeral director Wm Reuben Humphreys

Address Bethesda, Maryland

19. 10/11 1947 (Date rec'd by registrar) Wm E Jorley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/10 1947, at 9.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1939 to Oct 10 1947 and that I last saw him alive on Oct 10 1947

Immediate cause of death	DURATION
Acute heart failure	1 week
Due to Hypertensive heart disease	2 years
Due to Hypertension	15 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Brent. Benjamin M.D. M. D. or other

Address Bethesda, Md. Date signed 10/11/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

09235

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2153 California Street, N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3. (a) FULL NAME: ROBBINS, Alfred McCallum

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Esther D. Robbins

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 12, 1887

8. AGE: Years	Months	Days	If less than one day
60	6	0	hrs. min.

9. Birthplace: Washington, D. C. (Town, county, and state)

10. Usual occupation: Retired Marine Corps Personnel

11. Industry or business:

FATHER — 12. Name: ROBBINS, Henry A. dec.

13. Birthplace: Mo.

MOTHER — 14. Maiden name: McCALLUM, Lillie dec

15. Birthplace: Va.

16. Informant: wife: Mrs. Esther D. Robbins

Address: 2153 Calif. St., N.W., Wash., D.C.

17. burial — Date thereof: 10-15-47 (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Joseph Gawler E.R.Y.

Address: 1756 Penn. Ave., N.W. Wash., D.C.

19. 10-13 47 — Mary Charlotte Smith

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12 1947 at 11:50P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 Sept. 1947 to 12 Oct. 1947 and that I last saw him alive on 12 October 1947

Immediate cause of death	DURATION
Coronary artery Thrombosis with Myocardial infarction	14 days
Due to Arteriosclerotic Heart Disease	12 years
Due to Generalized Arteriosclerosis	(12 years)
Other conditions Hypertension	2 Hypertension
Cerebral Thrombosis (artery)	4 years

(Include pregnancy within 3 months of death)

Major findings of operation: none

Date of op.:

Autopsy results: Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

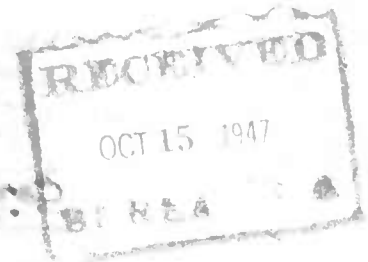
23. SIGNATURE: T. E. Jarrett. T. E. JARRETT, Cdr. MC USN (M. D. or other)

Address: USNH Bethesda, Md. Date signed: 10-13-47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING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09236

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

182

CERTIFICATE OF DEATH

Reg. Dist. No. 314

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~How long~~ street address where death occurred:
10145 Sutherland Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 10145 Sutherland Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Judith Ann Roberge

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: x
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 4th. 1947

8. AGE: Years	Months	Days	If less than one day
0	4	5	hrs. min.

9. Birthplace: Winchester, Va.
(Town, county, and state)

10. Usual occupation: x

11. Industry or business

FATHER
12. Name: James Davis Roberge
13. Birthplace: Westwood, N. J.

MOTHER
14. Maiden name: Velma Lee Pannett
15. Birthplace: Frederick Co. Va.

16. Informant: Mr. James D. Roberge
Address: 10145 Sutherland Rd.

17. Removal & Burial Date thereof: 10/27/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Westwood Memorial Cemetery
Location: Westwood, Bergen Co. N. J.

18. Funeral director: Wayne E. Pumphrey
Address: Silver Spring, Md.

19. Oct 26 1947 Josephine M. Schaffe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 25 1947, at 5:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. Med. Exam 1947, to 1947
and that I last saw h alive on 1947

Immediate cause of death	DURATION
Asphyxia due to Vomitus	Immediate
Due to (accidental)	Unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accidental Date of 10-25-47
Where did injury occur? Silver Spring (City or town) Monty (County) Md (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Asphyxia Injured at work? no

23. SIGNATURE: Frank J. Broschart M.D.
Sept. Med. Exam
M. D, or other
Address: Gaithersburg Md. Date signed 10-25-47

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

09237

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55 2 X

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mons. 6 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 mons., 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: N.C. County:

City or town: Ashville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 27 Washington Road
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3. (a) FULL NAME: RUSSELL, William Fred

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 16, 1896

8. AGE:

Years	Months	Days	If less than one day
51	1	9	hrs. min.

9. Birthplace: Tenn.
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business:

FATHER
12. Name: RUSSELL, Frank Winter dec.
13. Birthplace: Ohio

MOTHER
14. Maiden name: CRISP, Dora dec
15. Birthplace: North Carolina

16. Informant: Sister: Mrs. R. J. Worley

Address: 27 Washington Road, Ashville, N.D.

17. burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Lewis Memorial

Location: Ashville, N. C.

18. Funeral director: W. W. Chambers J.W.C.

Address: 1400 Chapin St., N. W., Wash., D.C.

19. 10-28 19 47 Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 28 19 47 at 4:10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 22 August 19 47 to 28 October 19 47

and that I last saw him alive on 28 October 19 47

	DURATION
Immediate cause of death: Cardiac Failure	2 mos.
Due to: Liposarcoma, Abdominal	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Liposarcoma, Abdominal Date of op.

Autopsy results: Generalized liposarcomatosis

PHYSICIAN: Please underline the cause for which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. B. Yowell, Jr. W. B. YOWELL, Jr., Lt.JG MC USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed 10-28-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

09238

CERTIFICATE OF DEATH

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 hrs.

Hospital, institution, or street address where death occurred: Washington San. & Hospital

How long in hospital or institution? 8 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: District of Columbia County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1807 - 41st Pl. S.E.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Phillip Schneider

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Sallie P Schneider

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 15, 1869

8. AGE:

Years	Months	Days	If less than one day
78	7	2	hrs. min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual occupation: Steam Engineer

11. Industry or business: Langsdorf & Bro.

FATHER 12. Name: Phillip Schneider

FATHER 13. Birthplace: France

MOTHER 14. Maiden name: Mary Dilger

MOTHER 15. Birthplace: Holland

16. Informant: Wash. San. Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 21, 1947 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cem.

Location

18. Funeral director: The L. B. Tines Co.

Address 2901 14th St. N.W.

19. Oct 18 1947 (Date rec'd by registrar) J. Wm. Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 - 17 - 1947 at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 1947 to Oct 17 1947 and that I last saw him alive on 10 - 17 - 1947

	DURATION
Immediate cause of death: Congestive Heart failure	2 Days
Due to: Left Bundle Branch Block	Months
Due to: Arteriosclerotic Heart Disease	Years
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. L. Sundy, M.D. M. D. or other

Address 1503 Good Hope Rd. (No.) D.C. Date signed 10-17-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09239

108

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hours

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Kennsington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 55 Carol Place

(If rural, give LOCATION)

2.(a) If veteran, name war: WW2

3. (a) FULL NAME: SCHOOLEY, Thomas Ira

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 10-1918

8. AGE:

Years	Months	Days	If less than one day
28	11	0	hrs. min.

9. Birthplace: Washington, D. C. (Town, county, and state)

10. Usual occupation: Delivery Man

11. Industry or business: Lang's Dry Cleaning, Wash., D.C.

FATHER

12. Name: SCHOOLEY, Ira Porter

13. Birthplace: unknown

MOTHER

14. Maiden name: SAYERS, Fredda

15. Birthplace: unknown

16. Informant: Mother: Mrs. Fredda A. Wells

Address: 55 Carol Place, Kennsington, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 10-13-47 (month) (day) (year)

Cemetery or crematory:

Location: Herndon, Virginia

18. Funeral director: Reuben Pumphrey, R.P.

Address: 7557 Wisconsin Ave., Bethesda, Md.

19. 10-10- 19 47 (Date rec'd by registrar)

Mary Charlotte Smith

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 October 19 47 at 11 A M

21. I CERTIFY that death occurred on the date above etated; that I attended deceaeed from October 10 19 47, to Oct. 10 19 47 and that I taet saw h... imalive on 10 Oct. 19 47

Immediate caose of death	DURATION
Lobar Pneumonia	Indef.
Due to	
Due to	
Other conditions	
Acute Hepatitis & toxic nephrosis	Indef.

(Include pregnancy within 3 months of death)

Major findings of operatioos: Date of op.:

Aotopsy resolts: same as above

PHYSICIAN: Please onderline the caose to which death should he charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Broschart

Frank J. Broschart, M.D. USN

Deputy Medical Examiner

Address: Gaithersburg, Md. M. D. or other

Date signed: 10-10-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09240

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: ~~4819 Avondale Road~~ 735 - 3d St. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: SCHORB, Fred Carl

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	widowed

6.(b) Name of husband or wife: Bessie Schorb

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 24, 1887

8. AGE: Years	Months	Days	If less than one day
60	8	16	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: unemployed

11. Industry or business:

FATHER
12. Name: Schorb, Fred C. dec.
13. Birthplace: Germany

MOTHER
14. Maiden name: Shüller, Lena dec.
15. Birthplace: Germany

16. Informant: sister: Mrs. Pauline Kern
Address: 4819 Avondale Road, Washington, D. C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 10-14-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS Esq.

Address: 517 11th St., S.E., Wash., D.C.

19. 10-10- (Date rec'd by registrar) 1947 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 October 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 October 1947 to 10 Oct. 1947 and that I last saw h... im alive on 10 October 1947

Immediate cause of death	DURATION
Pulmon. ary Tuberculosis	indef.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. H. O. Smith, Cdr MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 10-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09241

46 f x

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 11 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County:

City or town: Richmond
(If outside city or town limits, write RURAL and give nearest town)

Street No. 800 N. Shepard Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW2

3. (a) FULL NAME: SHOCKET, Abe

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Dora Shocket

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 14, 1902

8. AGE: Years	Months	Days	If less than one day
45	0	10	hrs. min.

9. Birthplace: Va.
(Town, county, and state)

10. Usual occupation: unemployed

11. Industry or business

FATHER
12. Name: SHOCKET, Bennie ded.
13. Birthplace: Russia

MOTHER
14. Maiden name: COEN, Fannie dec.
15. Birthplace: Russia

16. Informant: Wife: Mrs. Dora Shocket
Address: 800 N. Shepard St., Richmond, Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof 10-26-47 (month) (day) (year)

Cemetery or crematory: Workmen's Circle Cemetery

Location: Richmond, Va.

18. Funeral director: W. W. CHAMBERS Rus.

Address: 1400 Chapin St., N.W.

19. 10-24- 47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24 19 47, at 5:35A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 Sept. 1947, to 24 Oct. 1947 and that I last saw h im alive on 24 October 1947

Immediate cause of death	DURATION
Carcinoma of Common Bile duct with metastasis to liver and regional nodes.	9 mons.
Due to: Thrombosis of left common iliac	3 wks.
Due to: Pulmonary thrombosis & infarct (recent	48 hrs.
Other conditions: Pulmonary congestion & edema	48 hrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. G. Bell, Capt. MC USN M. D. or other

Address: USNH Bethesda, Md. Date signed: 10-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

09242

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, Institution, or street address where death occurred:
4725 Drummond Avenue
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4725 Drummond Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME
* * * * * MARGARET BRADY SHOEMAKER* * * * * * * * * *

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife William D. Shoemaker
6.(c) If alive, give age dec'd years

7. Birth date of deceased (mo., day, yr.) October 22, 1876

8. AGE: Years	Months	Days	If less than one day
71	0	3	– hrs. – min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Home

FATHER
12. Name John B. Brady
13. Birthplace Washington, D.C.

MOTHER
14. Maiden name Mary Margaret Ecroff
15. Birthplace Washington D.C.

16. Informant John B. Brady
Address Somerset, Maryland

17. Burial Date thereof 10/28/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt. Olivet Cemetery
Location Washington, D.C.
18. Funeral director Crudden & Cocaine
Address Washington, D.C.

19. Oct 26 1947 Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25th, 1947 at 4:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Dep. Med. Exam. Case	
Coronary Occlusion	Died Suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Broccard M. D. or coroner
Address Dep. Med. Exam. Gaithersburg, Maryland Date signed 10/25/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

Evedence for change of year of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G 113 OCT 27 1947 **CERTIFICATE OF DEATH**

48-L-1

69243

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Mont

City or town: Kensington Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 7 Franklin St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Kensington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: #7-Franklin St.

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3. (a) FULL NAME: Minnie Nixon Sillman

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Widowed.

6.(b) Name of husband or wife: Virgil Sillman

6.(c) If alive, give age: ~~24~~ years

7. Birth date of deceased (mo., day, yr.): Jan. 5. 1873 (1873)

8. AGE: Years	Months	Days	If less than one day
74			hrs. min.

9. Birthplace: Va. (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER — 12. Name: Samuel L. Nixon

13. Birthplace: Va.

MOTHER — 14. Maiden name: Blanch E. Elgin

15. Birthplace: Va.

16. Informant: Mrs Mary N. Durrie

Address: #3. Franklin St. Kensington MD.

17. (Burial, cremation, or removal. Which?) Date thereof: 10/24 (month) (day) (year)

Cemetery or crematory: Union Cem

Location: Leesburg Va

18. Funeral director: W.W. Chambers Co.

Address: 3072. M. St N.W.

19. 10/21 1947 (Date rec'd by registrar) Mm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 21 1947 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 22 1945 to Oct 21 1947 and that I last saw h.. alive on Oct 21 1947

Immediate cause of death	DURATION
Carcinoma of Uterus	4 years
Due to: with Metastases	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Bradley L Hodgkiss MD M. D. or other

Address: 313 W. Bradley Lane Chevy Chase 15 MD Date signed: 10/21/1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09244

92e

CERTIFICATE OF DEATH

Reg. Diat. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County Montgomery

City or town Colesville, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Colesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph Pete Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	married

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19th 1884

8. AGE:

Years	Months	Days	If less than one day
63	2	25	hrs. min.

9. Birthplace Maryland.

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Pete Smith

13. Birthplace Maryland

MOTHER 14. Maiden name Laura Watts

15. Birthplace Maryland

16. Informant Lillie Smith

Address Colesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 18, 1947 (month) (day) (year)

Cemetery or crematory Good Hope,

Location Colesville, Md.

18. Funeral director Robert L. Snowden

Address 246-N. Wash. St. Rockville

19. (Oct. 18 1947 (Date rec'd by registrar) Josephine M. Schaefer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1947, at 11:45 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 14 1947, to October 15 1947

and that I last saw h. alive on October 15 1947

Immediate cause of death	DURATION
Coronary Thrombosis	immediate
Due to Myocarditis and	Feb 1947
Endocarditis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Nebeker Sewell M.D.

M. D. or other

Address Norbeck Md Date signed 10-17-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09245

Reg. Dist. No. 316

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 10-21-'47

Hospital, institution, or street address where death occurred: Suburban Hosp
8600 Old Georgetown Rd, Bethesda Md.

How long in hospital or institution? Since 10-21-'47

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8603 Irvington Ave
(If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME SMITH, Lulu Blanche

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) ~~Single, married~~, widowed, or ~~divorced~~
F	W	

6.(b) Name of husband or wife Fred R. Smith

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 19, 1882

8. AGE: Years	Months	Days	If less than one day
65	2	11	..... hrs. ..... min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Jantz

13. Birthplace Pennsylvania

MOTHER 14. Maiden name Ensminger (sp?)

15. Birthplace Pennsylvania

16. Informant Hospital Records

Address Bethesda, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/3/47 (month) (day) (year)

Cemetery or crematory Mt. Vernon Cemetery

Location Allegheny Co., Clairton, Pa.

18. Funeral director Wm Reuben Humphrey

Address Bethesda, Maryland

19. 10/30 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30 1947 at 8 35 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 October 1947 to 30 Oct 1947 and that I last saw h.. alive on 29 Oct. 1947

	DURATION
Immediate cause of death Uremia -	4 days.
Caused by Toxic Nephritis -	
Due to Necrosis of Rt leg -	6 days.
Due to Embolism + Thrombosis of Rt Iliac artery dev.	20 Oct 47.
Other conditions Emboli from cardiac Fibrillation -	

(Include pregnancy within 3 months of death)

Major findings of operations Embolism + Thrombosis of Rt Iliac artery Date of op. 21 Oct 47.

Autopsy results Confirmed above - Infarct of Spleen.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John G. Bell M.D.
M. D. or other

Address 8956 Georgetown Rd Bethesda Date signed 30 Oct 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1310 09246

CERTIFICATE OF DEATH

Reg. Diat. No. 2 23

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, Institution, or street address where death occurred: Washington Sanitarium and Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: District of Columbia County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 750 Quebec Place

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mr. Joseph Snyder

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Jewish	Married

6.(b) Name of husband or wife: Mrs. Bessie Snyder

6.(c) If alive, give age: 68? years

7. Birth date of deceased (mo., day, yr.): Unknown 1880

8. AGE:

Years	Months	Days	If less than one day
67			hrs. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER

12. Name: Morris Snyder

13. Birthplace: Poland

MOTHER

14. Maiden name: Annie (unknown)

15. Birthplace: Poland

16. Informant: David Snyder

Address: 739 Madison St. NW

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Beth Sholom (Cemetery)

Location: Bennings 3rd

18. Funeral director: Goldberg Funeral Home

Address: 4217 9th St NW

19. Oct 19 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 19 1947 at 1:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1947 to Oct. 19 1947 and that I last saw him alive on Oct. 18 1947

Immediate cause of death	DURATION
Uremia	6 mo.
Due to: Chronic Nephrosclerosis	years
Due to:	
Other conditions: Hypertension Cardiovascular disease (Include pregnancy within 3 months of death)	years.

Major findings of operations: —

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Russell A. Dunn, M.D.

M. D. or other

Address: Washington San. Takoma Pk. D.C. Date signed: Oct 19, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

69247

Reg. Dist. No. 714

1. PLACE OF DEATH:
County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
601 McNeill Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Illinois County Iroquois
City or town Loda
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME: May Anna Stevens

3.(b) Social Security Number: 361-07-9970

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Sylvester L. Stevens
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Febuary 5 1870

8. AGE: Years	Months	Days	If less than one day
77	8	25	..... hrs. ..... min.

9. Birthplace: Loda, Illinois (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: James Healy
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary J. Kenny
15. Birthplace: Ireland

16. Informant: Mr. Charles W. Stevens
Address: 601 McNeill Rd. Silver Spring

17. Removal & Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 31st. 47 (month) (day) (year)
Cemetery or crematory: Pine Ridge
Location: Loda, Illinois

18. Funeral director: Warner E. Pumphrey
Address: Silver Spring, Md.

19. Nov. 1 1947 (Date rec'd by registrar) Joseph M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30 1947 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1947, to October 1947, and that I last saw h.r alive on Oct 30 1947

Immediate cause of death	DURATION
Congestive Heart Failure	30 minutes
Acute Dilatation	
Due to Chronic myocarditis	4 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: C B Wardrop M.D. M. D. or other
Address 943 Bonifant St Silver Spring Date signed 11/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09248

181

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney Sandy Spring, R.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:

Montg County General Hospital, Inc

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Dickerson R.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Chas Stewart

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife Single

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1863 ?

8. AGE:

Years	Months	Days	If less than one day
84 ?			..... hrs. ..... min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual occupation Lock tender on

11. Industry or business C & O. Canal.

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden name Unknown

15. Birthplace "

16. Informant Relda Hausner

Address Dickerson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 23-47 (month) (day) (year)

Cemetery or crematory Boonsboro

Location Boonsboro, Md

18. Funeral director William B Hilton

Address Boonsville, Md

19 Oct 23 1947 (Date rec'd by registrar) Gertrude B Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1947, at 8 a.m. P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 3rd Med Exam 19.. to Oct 21 19..

and that I last saw h.. alive on .. 19..

Immediate cause of death	DURATION
1st 2nd & 3rd degree burns involving face, neck, chest, abdomen and thighs	10 hrs
Due to (accidental)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accidental Date of 10-21-47

Where did injury occur? Dickerson (City or town) Montg (County) Md (State)

Injured at home, farm, industry, public place (where?) home

Means of injury Smoking in bed Injured at work? no

23. SIGNATURE Frank J. Boorhaat M.D.
By med Exam
M. D. or other

Address Gaithersburg Md Date signed 10-21-47

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09243 1572

83a

Reg. Diat. No. 716

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 112 Battery Lane

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Rev. Frank E. Sutch

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widower

6.(b) Name of husband or wife: Helen D. Sutch

6.(c) If alive, give age ..... years

7. Birth data of deceased (mo., day, yr.): Oct-6-1874

8. AGE:

Years	Months	Days	If less than one day
73	—	—	..... hrs. ..... min.

9. Birthplace: Bristol, Penna. (Town, county, and state)

10. Usual occupation: Retired minister

11. Industry or business

FATHER

12. Name: William Sutch

13. Birthplace: Penna-

MOTHER

14. Maiden name: Gertrude Bradfield

15. Birthplace: Penna-

16. Informant: Mark Smith (Friend)

Address: 141 Locust Ave. Bethesda, Md

17. Burial — Date thereof: 10/9/47 (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory: Cedar Green, Clayton, N.J.

Location: Clayton, New Jersey

18. Funeral director: Wm. Reuben Pumphrey

Address: 7557 Wis. Ave. Bethesda, Maryland

19. 10/8 1947 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct-6, 1947 at 8 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 18, 47 1947, to Oct. 6 1947

and that I last saw him alive on Oct. 6 1947

Immediate cause of death	DURATION
Cardiac exhaustion	
Due to: Cerebral Hemorrhage	
Due to: ✓	
Other conditions ✓	

(Include pregnancy within 3 months of death)

Major findings of operations ✓ Date of op. ✓

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date of ✓

Where did injury occur? ✓ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ✓

Means of injury ✓ Injured at work? ✓

23. SIGNATURE: E. A. A. Dunn M. D. or other

Address: Bethesda 14, Md. Date signed: Oct 7 '47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
OCT 13 1947

09250

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 days

Hospital, Institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2126 Conn. Ave., Wash., D.C.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME

Taussig Joseph Knefler

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Married

6.(b) Name of husband or wife: Lulie Taussig

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 8-30-1877

8. AGE: Years	Months	Days	If less than one day
70	1	29	hrs. min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: U.S. Navy Retired

11. Industry or business

FATHER
12. Name: Edward D. Taussig
13. Birthplace: Missouri

MOTHER
14. Maiden name: Ellen Knefler
15. Birthplace: Kentucky

16. Informant: Wife: Lulie Taussig
Address: 2126 Conn. Ave., Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-31-47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: Joseph Gawlers Sons E. A. Y.

Address: 1756 Penna. Ave., NW, Wash., D.C.

19. 10-29 47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 October 1947 at 5:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 10 1947, to 29 October 1947 and that I last saw him alive on 29 October 1947

	DURATION
Immediate cause of death: Coronary Heart Disease	18 months
Due to: Generalized Arteriosclerosis	3 years
Due to:	
Other conditions: Bronchopneumonia	3 days
Stokes Adams Syndrome	18 months

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Thiel E. Jassett. M. D. or other

Address: USNH, Bethesda, Md. Date signed: 10-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09251

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since Sept 20, 1947

Hospital, institution, or street address where death occurred: Suburban Hosp. Bethesda, Maryland

How long in hospital or institution? since Sept. 20, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State ..... County .....

City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4631 - 41st St. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Mr John E. Taylor

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) ~~Single~~, married, ~~widowed, or divorced~~
M	W	

6.(b) Name of ~~husband~~ or ~~wife~~ Madima Taylor

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1873

8. AGE: Years	Months	Days	If less than one day
74	8	18	..... hrs. ..... min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation lawyer

11. Industry or business

FATHER 12. Name Judge Ambrose (or Anson) Taylor

13. Birthplace ?

MOTHER 14. Maiden name ? Eastlack

15. Birthplace ?

16. Informant Responsible

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/8/47 (month) (day) (year)

Cemetery or crematory Ft Lincoln Cem.

Location .....

18. Funeral director The S. H. Hines Co.

Address 2901 14th St. N.W.

19. 10/7 1947 Mr E Jones Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1947 at 2.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1946, to Oct. 7 1947 and that I last saw h. i.m. alive on 10-7 1947

Immediate cause of death	DURATION
Generalized Arteriosclerosis	
with Hypertension	
Due to Hypostatic Pneumonia	
Due to Uremic State	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE P. P. Andrews M.D.
M. D. or other

Address 4201 Farragut St. N.W. Washington D.C. Date signed 10-7-47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09252

94a1

CERTIFICATE OF DEATH

Reg. Dist. No. 514

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
On lot near 519 Harding Drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 519 Harding Drive
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Roy G. Temple

3.(b) Social Security Number: 579-03-3420

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of ~~husband~~ wife: Mary J.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 4th. 1883

8. AGE: Years	Months	Days	If less than one day
64	2	5	hrs. min.

9. Birthplace: Canada
(Town, county, and state)
10. Usual occupation: Retired Brick mason
11. Industry or business

FATHER
12. Name: John Temple
13. Birthplace: Petrolia, Canada

MOTHER
14. Maiden name: Mary Brown
15. Birthplace: Mich.

16. Informant: Mrs. Mary J. Temple
Address: 519 Harding Drive.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-13-1947 (month) (day) (year)
Cemetery or crematory: Colesville Methodist Ch.
Location: Colesville, Montg. Co. Md.
18. Funeral director: Chas. E. Pumphrey
Address: Silver Spring, Md.

19. Oct 11 1947 (Date rec'd by registrar) Josephine McSherry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 9 1947, at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. med. Exam 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank J. Beschaut M.D. Dep. med. Examr. M. D. or other
Address: Gaithersburg Md. Date signed 10-9-47

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct name if especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09253

1862

CERTIFICATE OF DEATH

Reg. Diat. No. 223

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
Wash. San & Hosp. Takoma Park
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 324 Peabody St., N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME Joseph Tenley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 29, 1928

8. AGE: Years: 19 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Apolinger Construction Co.

FATHER
12. Name: John Tenly
13. Birthplace: Washington, D.C.

MOTHER
14. Maiden name: Ada -----
15. Birthplace: Virginia

16. Informant: Mrs. Seek
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 11, 1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland, Maryland

18. Funeral director: The S. N. Nives Company
Address: 8901 - 14th St N.W. Wash. 9, D.C.

19. Oct 9 1947 (Date rec'd by registrar) Wilmer D. Bell, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/8/47 19 at 5:32 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on Post Mortem Warm 19

Immediate cause of death	DURATION
Fracture of Sixth cervical Vertebra with Compression of Cord	8 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: —
Date of op.
Autopsy results: Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 9/30/47
Where did injury occur? Silver Spring (City or town) Montgomery (County) Md (State)
Injured at home, farm, industry, public place (where?) Industry
Means of injury: Fell from scaffold Injured at work? Yes

23. SIGNATURE: [illegible] approves Path.
M. D. or other
Address: Sandy Spring Md Date signed 10/8/47

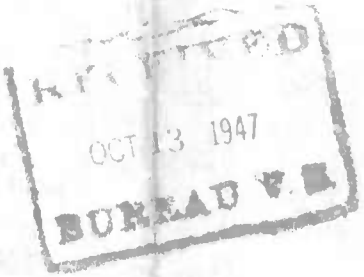
MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

The Coroner of Montgomery County
Dr. Bouchard has seen pt.
at 12 noon 10/8/47 in
autopsy
mortuary room and approved
autopsy.

Dr. Brennaman M.D.



C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09254

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:
County: Montgomery
City or town: Cabin John
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Cabin John
(If outside city or town limits, write RURAL and give nearest town)
Street No. 94 East End Place
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: OLA MAY TRAZZARE

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Charles W. Trazzare
6.(c) If alive, give age: 78 years
7. Birth date of deceased (mo., day, yr.): March 3, 1872

8. AGE: Years	Months	Days	If less than one day
75			hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business

MOTHER
12. Name: John W Grimes
13. Birthplace: Virginia

FATHER
14. Maiden name: Barbara R Robey
15. Birthplace: Maryland

16. Informant: Mr. Charles W. Trazzare
Address: 94 East End Place.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Oct 4 1947 (month) (day) (year)
Cemetery or crematory: Congressional Cemetery
Location: Washington, D.C.

18. Funeral director: J. William Lee Sons Co
Address: 300-4th St N.E. Wash, D.C.

19. Oct. 3rd 1947 (Date rec'd by registrar) Wm E. Lee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 1 1947, at 8:37 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1947, to Oct 1 1947, and that I last saw h.. alive on Sept 27 1947.

Immediate cause of death	DURATION
Cancer of rectum with metastases to liver.	
Due to	
Due to	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Joseph P. Kenick M.D.
M. D. or other
Address: 7942 Wisconsin Ave Date signed: 10/1/47
Bethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

09255

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

1. PLACE OF DEATH:
County 11- Aspen St. Mont.
City or town Ch. Ch. Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 11 Aspen St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Anna Underwood

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband or wife Jas. W. Underwood
6.(c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.) 3-4-1875

8. AGE: Years 72 | Months 7 | Days 27 | If less than one day ... hrs. ... min.

9. Birthplace alton, Illinois
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Charles Braguell
13. Birthplace England

MOTHER
14. Maiden name Henrietta Lund
15. Birthplace Connecticut

16. Informant (Mrs.) Mike (Irene) Underwood
Address 11 Aspen St, Ch. Ch. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 5-47 (month) (day) (year)
Cemetery or crematory Cedar Hill Cemetery
Location

18. Funeral director S. H. Nines Co. Washington, D.C.
Address 2901 - 14th St., N.W.

19. 10 31 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1947, at approx. 1:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 29 1947, to Oct 31 1947
and that I last saw her alive on Oct 29 1947

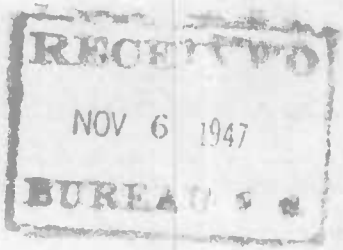
	DURATION
Immediate cause of death: Coronary occlusion	1 hour
Due to: Arteriosclerotic heart disease	1 month
Due to: Generalized arteriosclerosis	1 year or more.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Thomas C. N. Kinderman M.D.
M. D. or other
Address 6 West Washington St. Kensington, Md. Date signed 10/31/47


NOV 6 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

200 c 09256

Reg. Diat. No. 217

1. PLACE OF DEATH: Montg.

County Montgomery

City or town Sandy Farm near Olney

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hr

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... County .....

City or town .....

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Baby girl Unknown

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	single

6.(b) Name of husband or wife Unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE:

Years	Months	Days	If less than one day
new born			just born ..... min.

9. Birthplace .....

(Town, county, and state)

10. Usual occupation .....

11. Industry or business .....

FATHER

12. Name .....

13. Birthplace Unknown

MOTHER

14. Maiden name .....

15. Birthplace .....

16. Informant .....

Address .....

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 15 1947 (month) (day) (year)

Cemetery or crematory County Home

Location Rockville Md

18. Funeral director Robert J. Snouden

Address Rockville Md

19. 10-14 1947 (Date rec'd by registrar) Gertrude B Fawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Unknown about Oct 5 1947 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec med Exam 19..... to ..... 19.....

and that I last saw h..... alive on Dec 9 1947 19.....

Immediate cause of death	DURATION
Unknown	
Due to Found in Farm Yard	
Due to Dec Barnsley T. Olney M.D.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Unknown Date of Unknown

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frank J. Bouchart M.D. Dep Med Exam M. D. or other

Address Rockville Md Date signed 10-11-47

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09257

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since 10-27-'47
Hospital, institution, or street address where death occurred: Suburban Hosp 8600 Old Georgetown Rd-Bethesda Md.
How long in hospital or institution? Since 10-27-'47

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town 606 Thayer Ave. Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME Mr Lee Ward

3.(b) Social Security Number Unknown

4. Sex	5. Color or race	6.(a) ~~Single, married, widowed~~, or divorced
M	W	

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 31, 1893

8. AGE: Years	Months	Days	If less than one day
54	7	28	hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Salesman Safeway Cleaners
11. Industry or business

FATHER
12. Name Geo. Thomas Ward
13. Birthplace Maryland

MOTHER
14. Maiden name Martha Whalen
15. Birthplace Maryland

16. Informant Grace Moulden (friend)
Address 9408 Grayson Ave. Silver Spring Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/31/47 (month) (day) (year)
Cemetery or crematory Forest Oak Cemetery
Location Gaithersburg, Maryland

18. Funeral director Wm Reuben Humphrey
Address Bethesda, Maryland

19. 10/30/1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29 1947, at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 27 1947, to Oct. 29 1947
and that I last saw h.i.m. alive on Oct. 29 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	3 days
Due to: Hypertensive Cardio vascular disease	Unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank A. Zack M.D. M. D. or other
Address 8248 Ga Ave Silver Spring Md Date signed 10-30-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93a

09260

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? week
Hospital, institution, or street address where death occurred:
10000 Georgia Avenue
How long in hospital or institution? Week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7117 Curtis Street
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: **********DELIA S. WELCH **********

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: James H. Welch (deceased) 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 14, 1862

8. AGE: Years	Months	Days	If less than one day
85 85	0	4	— hrs. — min.

9. Birthplace: Rutland, Vermont (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Patrick Lynch
13. Birthplace: Ireland

MOTHER
14. Maiden name: Bridget O'Brien
15. Birthplace: Ireland

16. Informant: Mr. Harry Welch (son)
Address: Chevy Chase, Maryland

17. Burial-Transit (Burial, cremation, or removal. Which?) Date thereof: Oct. 19, 1947 (month) (day) (year)
Cemetery or crematory: Calvary Cemetery
Location: Rutland, Vermont

19. Funeral director: Wm. Reuben Pumphrey
Address: Bethesda, Maryland

19. Oct 18 19 47 (Date rec'd by registrar) Joseph Wm Schaefle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18 19 47, at 3:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 19 47, to Oct. 18 19 47
and that I last saw h... alive on Oct. 18 19 47

Immediate cause of death	DURATION
Acute Myocarditis	
Due to: Senility	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: No operations
Date of op.:
Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Henry Lee Lowden M.D. (M. D. or other)
Address: 1603 19th St. N.W. Washington, D.C. Date signed: 10-18-47

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83ar

09258

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No: 1617 T Street, S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: WWI

3.(a) FULL NAME: WHITE, Thomas Edward,

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 6 July 1895

8. AGE:

Years	Months	Days	If less than one day
52	2	26	hrs. min.

9. Birthplace: Penn. (Town, county, and state)
10. Usual occupation: Navy Yard
11. Industry or business

FATHER
12. Name: Thomas White DD
13. Birthplace: Scotland

MOTHER
14. Maiden name: Margaret Moran DD
15. Birthplace: Pa.

16. Informant: daughter: Miss Hariet White
Address: 1617 T St., S.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 10-6-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.
18. Funeral director: W. W. CHAMBERS WWC
Address: 517 11th St., S.E., Wash., D.C.
19. 10-2- 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 October 1947, at 1:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 29 Sept. 1947, to 2 Oct. 1947 and that I last saw him alive on 2 Oct. 1947

Immediate cause of death	DURATION
Primary atypical Pneumonia	4 days
Due to: massive cerebral hemorrhage	6 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results: massive Pneumonia and cerebral hemorrhage
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. L. Fleck R. L. FLECK, Lieut. MC USNR
M. D. or other
Address: USNH Bethesda, Md. Date signed: 10-2-47

VS A15 9-45-5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

CERTIFICATE OF DEATH

Reg. Dist. No. 09259 213

1. PLACE OF DEATH:

County: Montgomery

City or town: Rockville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Feb. 15, 1931

Hospital, institution, or street address where death occurred:
Chestnut Lodge Sanitarium

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

X

State: Pa. County: Armstrong Co.,

City or town: Apollo, Pa.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 508 North Armstrong Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: No ✓

3.(a) FULL NAME: Mrs. Sarah E. Willard

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: T. M. Willard, Dec.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 15, 1862

8. AGE: Years	Months	Days	If less than one day
(85) 85	0	16	..... hrs. ..... min.

9. Birthplace: Logansport, Pa.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: William F. Logan
13. Birthplace: Logansport, Pa.

MOTHER
14. Maiden name: Elizabeth Jane Bonney
15. Birthplace: Armstrong Co., Pa.

16. Informant: Chestnut Lodge Sanitarium
Address: Rockville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/31/47 (month) (day) (year)
Cemetery or crematory: Manor Cemetery
Location: Ford City, Pa.

18. Funeral director: Wm. Reuben Pumphrey
Address: 7557 Wis. Ave. Bethesda, Maryland

19. 10/31 (Date rec'd by registrar) 1947 E. P. Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 31 Oct. 1947 at 2 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1947 to 31 Oct 1947
and that I last saw her alive on 31 Oct 47 1947

Immediate cause of death	DURATION
Arteriosclerotic heart disease with decompensation	
Due to	
Due to	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Stanley A. Cloud, M.D. M. D. or other

Address: Chestnut Lodge Sanit. Date signed: 31 Oct 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

186a

09261

Reg. Dist. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Georgia County Putnam

City or town Eatonton
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war — —

3.(a) FULL NAME Mrs. Mary Emma Williams

3.(b) Social Security Number — —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Joseph Lane Williams

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 6, 1857

8. AGE: Years	Months	Days	If less than one day
89 ~~87~~ 89	11	27	..... hrs. ..... min.

9. Birthplace Putnam Co. Georgia
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Frank Hearne

13. Birthplace Georgia

MOTHER 14. Maiden name Mary Jane Pennington

15. Birthplace Pennington, Georgia

16. Informant Hospital records

Address

17. Removal Date thereof Oct 3, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Eatonton

Location Putnam Co. Georgia

18. Funeral director Warren D. Humphrey

Address Silver Spring, Md

19. Oct 3 1947 Gertrude B. Lawler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3 1947, at 7:05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 20 1947, to October 3 1947 and that I last saw her alive on October 3 1947

Immediate cause of death	DURATION
Acute cardiac failure	2 x hrs
Due to Fracture, right hip	13 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident, Date of 9/20/47

Where did injury occur? Between Mon Co Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Fall Injured at work?

23. SIGNATURE [signature]
M. D. or other

Address Sandy Spring, Md Date signed 10/3/47


RECEIVED
OCT 13 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1860 09262

Reg. Dist. No. 26

1. PLACE OF DEATH:

County Montgomery

City or town Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Sudden death-no stay

Hospital, institution, or street address where death occurred:

6307 Hillcrest Street,

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington, D.C. County XXXXXX

City or town Washington, D. C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 526 3rd Street, N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war Yes

3.(a) FULL NAME ---------JOHN WILVER----------

3.(b) Social Security Number 266-22-2598

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Helen Mae Wilver

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 16, 1902

8. AGE: Years	Months	Days	If less than one day
44	9	18	..... hrs. ..... min.

9. Birthplace Penna. (Town, county, and state)

10. Usual occupation Roofing Contractor

11. Industry or business

FATHER 12. Name Frank Wilver

13. Birthplace Penna.

MOTHER 14. Maiden name Lottie Snyder

15. Birthplace Penna.

16. Informant Mrs. Helen Mae Wilver

Address 526 3rd St. N. W. Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/9/47 (month) (day) (year)

Cemetery or crematory Forest Oak Cemetery

Location Gaithersburg, Maryland

18. Funeral director Wm R. Pumphrey

Address 7557 Wis. Ave. Bethesda 14, Maryland

19. 10/8 (Date rec'd by registrar) 19 47 Wm F Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4th, 19 47, at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death ..... DURATION

Dep. Med. Exam. Case

Due to Fracture of cervical Vertebrae died suddenly

Due to fall from roof of house he was repairing.

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accidental Date of 10-4-47

Where did injury occur? Chevy Chase (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?) 6307 Hillcrest St.

Means of injury fell from roof. Injured at work? Yes

23. SIGNATURE Fred J. Bouchard M. D. or other

Dep. Med. Exam.

Address Gaithersburg, Maryland Date signed 10/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15


RECEIVED
OCT 13 1947

09263

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

Reg. Dist. No. 7 14

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs

Hospital, institution, or street address where death occurred:

Chevy Chase Country Club

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Monty.

City or town: Chevy Chase (If outside city or town limits, write RURAL and give nearest town)

Street No. Chevy Chase Country Club (If rural, give LOCATION)

2.(a) If veteran, name war: retired Maj. Gen. of U.S.A.

3.(a) FULL NAME

Maj Gen. Blanton Winship

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): NOV 23 1869

8. AGE:

Years	Months	Days	If less than one day
77	9	16	..... hrs. ..... min.

9. Birthplace: Macon Ga (Town, county, and state)

10. Usual occupation: Retired U.S. Army.

11. Industry or business

FATHER

12. Name: Emory Winship

13. Birthplace: Ga.

MOTHER

14. Maiden name: Blanton

15. Birthplace: Ga

16. Informant: W. B. Lancaster

Address: Chevy Chase Club - Chevy Chase Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 11, 1947 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery.

Location: Macon, Georgia.

18. Funeral director: W.W. Chambers Co

Address: 1100 Connecticut Ave. N.W. Wash. D.C.

19. Oct 11 (Date rec'd by registrar) 19 47 Josephine E. Sheffe (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 9 19 47, at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec Med Exam 19.. to ..19.. and that I last saw h.. alive on ..19..

	DURATION
Immediate cause of death	
Coronary occlusion	about
Due to	ending
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank J. Brockett M.D. D. of Med Exam M. D. or other

Address: Gaithersburg Md Date signed 10-8-47

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.


RECEIVED
OCT 15 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

133a 09264

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 655 Anacostia Avenue, N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW2

3.(a) FULL NAME: YOUNGER, Willie Henry

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	married

6.(b) Name of husband or wife: Dollie Younger
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 22, 1912

8. AGE: Years	Months	Days	If less than one day
34	11	5	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: ~~unknown~~ Labor
11. Industry or business:
FATHER 12. Name: YOUNGER, Mose dec.
13. Birthplace: Va.
MOTHER 14. Maiden name: WINDBUSH,
15. Birthplace: Va.
16. Informant: wife: Mrs. Dollie Younger
Address: 655 Anacostia Avenue, N.E., Wash., D.C.
17. burial (Burial, cremation, or removal. Which?) Date thereof: 11-2-47 (month) (day) (year)
Cemetery or crematory: Triumph
Location: Chatham, Virginia
18. Funeral director: CAREY & LATNEY, Funeral Home
Address: 611 K St., N.W., Wash. D.C.
19. 10-28 47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 27 October 19 47 at 5:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 October 1947, to 27 October 1947 and that I last saw him alive on 27 October 1947

Immediate cause of death	DURATION
Pneumonia, etiology undetermined	6 days
Due to: Pyelonephritis	2 weeks
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. R. Cooper, Lt. MC USN (M. D. or other)
Address: USNH Bethesda, Md. Date signed: 10-28-47